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The Structural Approach of HIV Prevention: the Case of Female Sex Workers in Honduras

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The Structural Approach of HIV Prevention: the Case of Female Sex Workers in Honduras

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Dedication

To my parents, Amelia and Arcesio.

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Abstract

The Structural Approach of HIV Prevention: the Case of Female Sex Workers in Honduras

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The goal of this report was to assess current prevention strategies that attempt to reduce HIV prevalence among female sex workers (FSW) in Honduras. This analysis was based on the difference between behavioral change and structural approaches; that is, while behavioral change theories are based on risk reduction through promoting individuals' change, the structural approach addresses the factors in the environment that make individuals vulnerable to HIV. In order to analyze prevention strategies in

Honduras, I carried out an analysis of the structural conditions at the country level and, at the sex workers population level. The structural factors that make Honduras a country vulnerable to HIV are political instability, migrations, poverty and socio-economic conditions, and gender inequality. As a consequence of those macro-environmental conditions, sex workers face the following micro-environmental factors that increase their vulnerability to HIV: violence and male domination; large families and single parenthood; low income and poor education; and public policies against sex work, such as police abuse and closure of brothels. This report is based on an analysis of the Sonagachi Project in India, 100% Condom Use in Thailand, and the intervention in the Dominican Republic, programs that successfully address structural conditions and decrease women's vulnerability to HIV. This report showed that in Honduras, the prevention strategies currently implemented are limited because they are based on behavioral change theories, failing to address environmental barriers that increase vulnerability to HIV among FSW. I give some specific recommendations about how to improve prevention strategies in this country reducing women's vulnerability by addressing the structural factors they face.

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Glossary of Acronyms and Abbreviations

ABC: approach Abstinence, Being faithful and Condom use
AIDS: Acquired Immune Deficiency Syndrome
AMDA: Association of Medical Doctors of Asia
ARRM: AIDS Risk Reduction Model
ARV: Antiretroviral
BCC: behavioral change communication
COCSIDA: Center for Orientation and training in AIDS
COMSIDA: The National AIDS Commission
CONASIDA: National AIDS Committee
ENESF: Family Health Epidemiological Survey
FIDH: The International Federation for Human Rights
FSW: Female Sex Workers
GDP: gross domestic product
GLOBAL FUND: Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV: Human Immunodeficiency Virus
IEC: information, education and communication
INE National Institute of Statistic
IRB: institutional review board
Modemu: Movimiento de Mujeres Unidas
MSM: male who have sex with male
NGO: Non-Governmental Organization
PENSIDA I: first strategic plan on AIDS
PENSIDA II: second strategic plan on AIDS
PENSIDA II: third strategic plan on AIDS
PLHIV: people living with HIV
Prodim: Organization of Development Programs for Children and Women
Rimas: Rimas Cultural Association
STIs: Sexually Transmitted Infections
TRA: Theory of Reasoned Action
UNAIDS: The Joint United Nations Programme on HIV/AIDS
UNGASS: United Nations General Assembly
USAID: United States Agency for International Development
WHO: World Health Organization

CHAPTER ONE: READRESSING HIV PREVENTION STRATEGIES

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that from 1981 to 2007, 33 million people were diagnosed with HIV. Even though the global investment in AIDS response increased from 7.9 billion dollars in 2005 to 13.7 billion dollars in 2008, 2.7 million new infections occurred in 2007 compared with 3 million in 2005, which represents only a small reduction. HIV prevention efforts become critical when for every two people starting HIV treatment, another five are newly infected.[1] However, prevention has been a difficult task, because in order to reduce risky behaviors that lead to transmission, most of the strategies require behavioral changes. Changing behaviors has been costly, unsustainable, and to some extent ineffective, because this approach is mostly based on reaching rational individuals who have the ability to change their own lives. However, high HIV incidence rate is mostly found in vulnerable populations embedded in contexts that constrain their ability to adopt healthy practices that prevent HIV transmission. Female sex workers (FSW) are one of the populations that are targeted world-wide by HIV prevention strategies. Appropriate and consistent use of condoms is the most realistic and effective strategy to reduce the risk of sexual exposure to HIV among this population. However, consistent use of condoms requires making individual decisions that depend on social interactions and are constrained by structural barriers such as gender inequality, socio-economic status, and cultural beliefs. Therefore,

effective implementation of prevention strategies entails addressing the structural factors that undermine individual behaviors.

While most of the efforts to reduce HIV have focused on Africa because it has a generalized epidemic, little attention has been paid to regions where the epidemic is localized and concentrated on high-risk populations. Although HIV prevalence in Latin American countries is relatively low compared to the rates found in many parts of Africa, the number of people affected is still substantial, reason why there is a significant need for boosting HIV prevention efforts in this region. It is estimated that in Latin America there were 1.7 million people living with HIV and AIDS at the end of 2007. Of these, 140,000 were newly infected during 2007. In that same year it is estimated that 63,000 people died of AIDS.[2] Also, it is estimated that in Latin America and the Caribbean, only 14% of risky sexual acts are protected by condoms, which means that only a minority of the vulnerable population is effectively preventing the risk of HIV infection.[3]

Two of the countries with the highest incidence of HIV in Latin America are located in Central America: Belize and Honduras. In Honduras, the third poorest country in the Western Hemisphere after Haiti and Nicaragua, HIV and AIDS has had significant impact on vulnerable populations such as males who have sex with males (MSM), and female sex workers (FSW). Representing 18% of the Central American population, Honduras has the second HIV incidence of the region (0.8%), reporting 38.5% of the total cases. HIV is predominantly heterosexually transmitted, and it has low levels of transmission among drug users. FSW, MSM and Garifunas, an ethnic group with African

roots, are the populations with the highest HIV incidence in the country. MSM HIV incidence rose from 12% in 2002 to 13% in 2005. Among FSW, the incidence was between 10% and 20%[4] in 1998, in 2001 it was 9%, and in 2003 it was 9.68%.[5]

Unlike other countries in Latin America such as Peru and Mexico, where HIV is predominantly driven by MSM, in Honduras, a country that has historically had mostly heterosexual patterns of transmission, transmission between sex workers and their clients is recognized as a major factor in the spread of HIV.[6] In this sense, preventing female sex workers from acquiring HIV can play a vital role in restricting the overall spread of HIV in the country. Proof of this can be seen in countries such as India, the Dominican Republic and Thailand, where general reductions in the national HIV prevalence have been largely attributed to HIV prevention initiatives aimed at sex workers and their clients.

In Honduras, prevention strategies among FSW have focused on cognitive based approaches that aim to change their behaviors through communication, information and awareness about the risk and how to avoid it. On the other hand, more successful strategies in countries such as India, Thailand, The Dominican Republic and India have integrated structural factors such as reducing discrimination, decriminalizing sex work and empowering women. These interventions have demonstrated that governments and organizations can work together enabling sex workers to protect themselves by addressing the underlying social and economic problems that make them so vulnerable to HIV.

The goal of this report is to assess current prevention strategies that attempt to change individual behaviors among female sex workers in Honduras. This assessment is based on the difference between behavioral change and structural approaches for reducing the risk of HIV infection. Therefore, it is based on a diagnostic of the structural conditions that hinder female sex workers' individual choices and constrain their sexual behaviors. Based on evidence from international cases that have successfully addressed structural conditions, this report will show that in Honduras, the behavioral change approach is limited and prevention strategies should be designed and implemented to reduce specific environmental barriers that increase vulnerability to HIV among FSW. Based on a diagnostic of the targeted population, the objective of this report is to discuss to what extent and under what conditions successful prevention strategies in other countries can be implemented in Honduras. Based on this analysis, this report presents some specific policy recommendations about how to design prevention strategies that respond to the realities that sex workers face in this country.

The research question for this report is the following: Which strategies can realistically prevent HIV and promote healthy behaviors in the long run among female sex workers in Honduras? In order to answer this question, this report identifies whether or not structural factors exist that constrain female sex workers' individual behaviors. If so, should they be tackled through prevention programs, and to what extent should interventions among female sex workers address those main structural barriers that impede healthy behavior among women? The statement of this report is that interventions that address structural factors can be more effective and less expensive in the long run

than interventions that only address individual risk. Prevention programs should be based on a true understanding of the socio-economic context, and the structural causes of disease that are generated by the environment, not only by individual behaviors.

This report is organized as follows: The second chapter explains the different theories behind HIV prevention, differentiating between cognitive theories and structural approaches. This chapter also explores successful structural interventions among sex workers in other countries such as India, Thailand, and The Dominican Republic. The third chapter is an exploration of how the HIV epidemic has evolved in Honduras, and which conditions have driven the epidemic. The fourth chapter analyzes specific conditions of sex workers in Honduras and identifies the structural barriers for preventing HIV; it also analyses several prevention strategies that are currently being implemented by local organizations. The question underlying this analysis is to what extent those prevention strategies address environmental/structural conditions that cause risk among female sex workers. Finally, the fifth chapter presents conclusions and recommendations of how successful international cases can be adapted to the Honduran context and how prevention strategies can realistically incorporate structural factors to promote healthy behaviors in the long run among female sex workers.

This report attempts to give realistic recommendations for organizations that work with female sex workers in Honduras. In order to achieve this goal, the information collected here tries to gather opinions from different stakeholders, such as organizations that work in prevention, female sex workers living with HIV, and women leaders of the

community. Therefore, the report is based on different types of qualitative methods for data collection. A first phase was conducted during summer 2009.[1] During this time, I not only observed and interviewed female sex workers, but I also interviewed members of other vulnerable populations such as MSM, prisoners, *garifunas*, pregnant women, young populations, and people living with HIV.[2] I conducted a total of 80 semi-structured interviews, which make me aware that the vulnerable populations are so, because they face similar socio-economic, political and cultural conditions that put them at risk.[3] I also realized that HIV infection is then a result of those conditions, and in order to implement effective interventions, they must consider environmental factors. During this phase, I also conducted semi-structured interviews with eight female sex workers and three managers in three different brothels.

In a second phase, I carried out in-depth semi-structured interviews with eleven female sex workers, one former sex worker who has HIV, and another former sex worker who is the leader of a community-based organization of FSW with ample experience in HIV prevention among this population. The goal of these interviews was to identify the factors that put them at risk of HIV infection. Another important goal of these interviews was to gather their opinions about the currently implemented prevention programs in Honduras, and how they can be improved based on successful experiences in other

1 During this time, I did my internship in CHF International, an NGO that is the main recipient of support from The Global Fund in Honduras 2008-2014. This research has CHF International's approval.

2 Due to re-infection, people living with HIV are still vulnerable to the virus.

3 Based on this work, I wrote a book called "Huellas de Vida" (Traces of Life), a compilation of 12 stories about the prevention and care interventions by the Program "Strengthening the National Response for Health Promotion and Protection of Health and in HIV/AISD", implemented by CHF International and supported by The Global Fund

countries. Finally, in order to analyze current interventions, I analyzed two projects implemented by two local NGOs and financed by international cooperation. The first one is Salvando Vidas (Saving Lives) implemented by the Association of Medical Doctors of Asia-AMDA and Rimas Cultural Association. This project is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and implemented by CHF International. The second one is called Alejandra y la Vida (Alejandra and Life), implemented by the Center for Orientation and training in AIDS- COCSIDA, and financed by USAID. Both organizations, COCSIDA and CHF International gave me their authorization and approval to analyze their projects

.

CHAPTER TWO: THEORIES BEHIND HIV PREVENTION: A HISTORIC OVERVIEW

HISTORIC EVOLUTION OF PREVENTION STRATEGIES

Almost 30 years after the first HIV case was detected, there have been few advances on biomedical HIV prevention modalities. Therefore, prevention efforts still rely almost entirely on people's capacity to influence their own behavior and their social environment to reduce transmission.[7] The dominant discourse in the history of HIV prevention has been based on the idea that if people are informed about HIV risk, modalities of transmission, and methods of preventing risk, and they acquire the skills to change themselves, they change their behavior in order to reduce the risk. This cognitive, psychological and individualistic approach is the base of the majority of theories that support HIV prevention.

Historically, there has been modest change in the approaches to HIV prevention. The first stage of HIV prevention took place in the 1980s,[8] when it was mainly homosexuals who were identified as risky populations. HIV prevention strategies started being implemented in the United States and had a community-based approach. Led principally by gay activist groups in the United States, these interventions advocated for safe sex through condom use and self-empowerment.[9]

Prevention strategies began being established elsewhere in the world in the late 1980s. In 1987 The World Health Organization (WHO) designed the first Global AIDS Program in response to the epidemic. In the 1990s most of the developing countries established their own national responses with resources from international cooperation. These responses were criticized because they were based mainly on top-down approaches that intended to universally replicate strategies based on behavioral changes and social marketing. These strategies lacked ownership and did not produce commitment from national leadership;[10] they were unable to get national leaders sufficiently engaged.[11] Also, since these strategies were focused on some vulnerable groups targeted as highly risky, interventions caused high levels of stigma and discrimination against them. These populations, led mainly by the gay community, advocated for a change in the approach.

In the second stage, risk was linked more with specific practices than with specific populations. A causal mechanism of transmission was associated with specific individual practices and behaviors -such as anal penetration- rather than with the characteristics of certain groups. The goal in this stage was to eradicate risk.[12] During this time, the models of rational individuals and beliefs were developed and started to be implemented. Although during this stage interventions tried to be more oriented toward practices than toward specific groups, in reality strategies were still designed and focused on vulnerable populations. The first and the second stage were information-based approaches that aimed to reduce the need for risk education services. The assumption was

that more information, education, and communication about behaviors associated with transmission would lead to a reduction of risky behaviors.

BEHAVIORAL CHANGE THEORIES

Some of the most commonly used individual-level theories of health behavior and behavior change include the Health Belief Model, AIDS Risk Reduction Model (ARRM), Theories of Reasoned Action and Stages of Change and Social Cognitive Theory.[13] Most of these theories associate health behavior with attitudes, social influence, self-efficacy and intentions or stages of change.[14] The Health Belief Model is a cognitive model for understanding health risk behaviors that provided the basis of most prevention-focused interventions. According to this model, preventive health behaviors are dependent on four factors that outline the perceived threat of risk: perception of susceptibility to an adverse health condition, perception of severity of the adverse health condition and its consequences, perception of the benefits of changing behaviors to reduce the threat, and perception of barriers or negative consequences that may result from taking particular health actions. The health belief model helps to explain health related behaviors by identifying their causes and methods of change. Based on this model, persuasive messages and campaigns were developed about the severity of AIDS and its consequences, and how to make choices for healthy behaviors to avoid risk.

The AIDS Risk Reduction Model (ARRM) is also based on individual risk reduction and incorporates several components from the Health Behavioral Model. ARRM, like the Stages of Change Model, identifies stages in which changes take place, and the factors needed to fulfill the completion of each stage. The Theory of Reasoned Action (TRA) links individuals with beliefs, intentions, behaviors, and attitudes and is based on the rationality of individuals.

The Social Cognitive Theory introduced new concepts that can be considered as part of a third stage of prevention approaches. Based on the idea that health knowledge is not sufficient for effective self-protection against HIV, and that risk is also based on interpersonal relationships, Social Cognitive Theory[15] adds the idea of self-efficacy to the Health Behavioral Model. The idea of self-efficacy is based on the statement that besides knowledge, people require skills and self-beliefs to enable them to put knowledge into practice. In this third stage, previous models tend to coexist. However, contextual factors are taken into account, such as the characteristics of relationships and the interactions in which risk takes place. Prevention programs aim to achieve a more realistic goal; that is, instead of trying to eliminate risk (safe sex), the goal now is to promote safer sexual practices.[16]

Today, other concepts such as risk environment and vulnerability have added complexity to the discussion of prevention. The concept of risk environment is defined as a social and economic environment in which the chances of disease transmission are increased as a result of social, economic and cultural factors. In a risky environment

predisposition to virus transmission is increased. Closely related to risk environment, vulnerability is a concept that frames most of the interventions, since the majority of prevention strategies are focused on reducing risk among vulnerable populations. Vulnerability refers to a higher exposure to risk, a difficulty in facing it.[17] According to Delor and Hubert, risk has two sides, external and internal.[18] The risk of exposure is determined by a set of factors that increases the risk of HIV infection. Exposure is high, for example when individuals engage in risky behaviors in environments where HIV incidence is already high. There is also a risk of lacking the right resources when facing high exposure, which limits individuals' capacity to manage risky situations. Besides exposure and capacity, another source of vulnerability is potentiality, which refers to the potential of serious consequences as a result of acquiring the infection. The consequences can be more severe, for example, in a country where people lack access to health care. According to this model, the vulnerability associated with sexual relationships has different levels of risk, individual and interpersonal interaction, and social context. All these dimensions are essential in determining the level of vulnerability to HIV.

The majority of the prevention programs implemented today are based on promoting safer and healthier sexual practices through behavioral change, mainly among populations with high HIV prevalence. Most are based on cognitive behavioral approaches that include social innovation or peer education, or a combination of both. These approaches involve individuals, families, small groups and/or communities, and they aim to identify situations of vulnerability in which intervention programs should

intervene. Four of the most widely accepted and currently used concepts in prevention are the ABC approach (Abstinence, Being faithful and Condom use), launched mainly by the United States government, peer education, behavioral change communication (BCC), and information, education and communication (IEC). The ABC approach gives the guidelines for prevention based on three main strategies: Abstinence, fidelity, and consistent and correct use of condom. Peer education is the methodology most currently used for prevention and it is based on the idea that people's peers influence their decisions regarding their health behaviors. IEC and BCC are cognitive approaches that aim to improve awareness and to reduce HIV/AIDS related stigma and discrimination.

Even though, interventions based on awareness and knowledge are the most commonly used for prevention, these approaches have turned out to be very limited. Almost 30 years after implementation, these prevention programs have not produced a significant global impact in HIV incidences. According to UNAIDS, prevention services currently reach less than 10% of individuals at risk worldwide, and less than one person in five at risk of HIV infection had access to HIV prevention services.[19] UNAIDS states that "the number of new infections –five million per year- must be dramatically reduced in the next few years to ensure that antiretroviral treatment scale-up remains economically and socially sustainable."[20] In order to make progress toward the goal that the UN World Summit established in 2006 of reaching universal access to HIV prevention and care by 2010, a different approach is necessary to make prevention cost-

effective, affordable, sustainable, and more accessible to those excluded from access to health and services.

Several studies have pointed out the limitations of the behavioral change approach, mainly because it requires one-on-one educational strategies.[21] The behavioral change approach assumes that awareness and knowledge motivate individuals to change, and that individuals have the power to take protective actions. These interventions do not have a large impact, because they are focused on individuals and small groups and they lack strong institutional support and committed and sustained leadership, which are essential factors to assure sustainability and long-term impact of change. Due to these approaches' limited efficacy and lack of sustainability,[22] studies have found that interventions based on behavioral change are necessary but not sufficient.[23] Even though prevention strategies require continual behavioral change to be effective, those studies state that it is necessary to consider other factors that depend on the context and environment of the specific targeted populations and on which individuals have limited control.

THE STRUCTURAL APPROACH OF PREVENTION

UNAIDS' current policy approach states a need for bridging the prevention gap through long term and structural strategies.[24] Structural strategies are prevention strategies that address the common root causes that have driven the spread of HIV

infection, such as gender inequality, poverty and the social marginalization of the most vulnerable populations.[25]

While behavioral strategies motivate change within individual and social units by using educational and motivational methods, structural strategies aim to change the contexts that contribute to vulnerability and risk where health outcomes are produced.[26] Therefore, one-on-one interventions can be more easily implemented than structural interventions, because the latter implies changes in policies, laws, culture or social practices that require synergies, consensus and often struggle and transformation.[27]

According to Gupta et al., "the [structural] approach is different from more individually oriented behavior change efforts because it addresses factors affecting individual behavior rather than targeting the behavior itself."[28] Structural interventions may tackle the individual, organizational or environmental levels by focusing on strategies that assure the availability, acceptability and accessibility of the conditions required for reducing risk.[29] Structural factors are based on the assumption that social, economic and political factors constrain individual, community and societal health outcomes.[30] These factors are seen also as barriers to or facilitators of individuals' HIV prevention behaviors because they can directly or indirectly affect an individual's ability to avoid exposure to HIV.[31] Structural factors are recognized as conditions that increase HIV risk and vulnerability. The application of structural strategies in prevention programs has been hindered, however, because it is difficult to design practical strategies

that address those structural factors. Also, there is insufficient evidence to actually prove the effectiveness of structural approaches in reducing HIV incidence.[32]

Which structural factors?

There have been several attempts to classify the structural factors that increase vulnerability to HIV among populations. Barnett and Whiteside differentiate between proximal and distal [distant] factors.[33] The authors classify distal factors, which have a more indirect causal link, as macro-environmental conditions such as national economy and governance. More closely related causal conditions are classified as micro-environmental factors and are associated with characteristics of the local context. Swat and Denison differentiate between super-structural factors such as economic development, structural factors such as law and policies, environmental factors, such as living conditions and opportunities available, and individual factors that are determined by how individuals experience environmental factors.[34] Based on the previous classifications, Gupta et al. identifies how gender inequality can influence risky behaviors among women.[35]

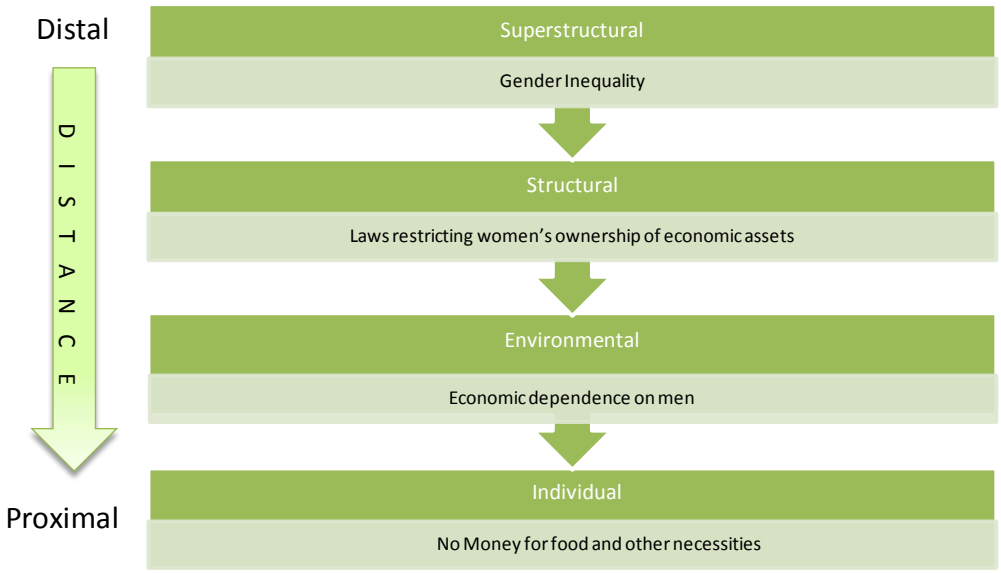

Figure 1: Use of two frameworks to analyze how a structural factor (gender inequality) might lead women to risk behavior
Source: Adapted from Gupta et al. (2008)

Klein et al. group structural factors into three different categories: "(1) economic (under)-development and poverty; (2) mobility, including migration, seasonal work, and social disruption due to war and political instability; and (3) gender inequalities.[36] Economic development and poverty have been identified as major structural causes of HIV incidence, especially when they are linked to inequality, exclusion and discrimination. Migration, population movement and political instability make up another set of major causes linked with vulnerability. The mobility of men has been related to increased visits to female sex workers, which increase the risk of HIV and sexually transmitted infections (STI). Men's leaving their households due to migration exacerbates women's poverty conditions, which in turn increases women's likelihood of becoming

sex workers. Migration can also spur the spread of HIV from regions and populations with high levels of incidence to those with low prevalence levels. Social and economic disruption caused by war and political instability can increase poverty and inequality, increasing the vulnerability of the most vulnerable populations and the presence of all the factors that facilitate HIV transmission. Finally, gender inequality is a main barrier for HIV prevention and a factor that facilitates the spread of HIV. Factors linked with gender inequality, such as domestic violence, economic dependence on men, lack of women's opportunities to access property, income, and education are closely linked with their capacity to negotiate condom use and their ability to adopt safer sexual behaviors.

These different classifications of structural factors are used in the following chapters in order to frame the contextual analysis to diagnose the structures that have a higher impact in HIV incidence in Honduras. Those macro-environmental conditions are the base of the analysis of the micro-environmental conditions that specifically affect female sex workers in Honduras. The goal is to identify which structures are causing the problem among this population and how can they be tackled in order to reduce vulnerability.

Successful structural interventions

The majority of successful structural interventions have sought to alter the conditions in which sex work takes place.[37] They are based on the idea that HIV prevention must go beyond female sex workers' individual choices, and tackle the

barriers that determine health outcomes. Three of the most well known interventions have been implemented in India, Thailand and The Dominican Republic.

The Sonagachi project

Sonagachi is the largest red-light district in Kolkata, India. It is an area with several hundred brothels and some 10,000 sex workers. The Sonagachi project began in 1992 with the purpose of reducing female sex workers' vulnerability to HIV transmission. As a result of the project, condom use among sex workers increased from 2.7 in 1992 to 89.5 in 2008. Unlike other prevention programs, "the Sonagachi Project was largely unplanned and atheoretical at its inception—it began as an STD clinic targeting sex workers."[38] The goal was to create an enabling environment based on three R's: 'respect' for sex work and those engaged in it; 'reliance' on those involved in sex work to run the program; and 'recognition' of their professional and human rights.[4] Based on the short-term goal of increasing consistent use of condoms and decreasing STIs in order to reduce HIV incidence, the project slowly incorporated long-term goals that have enabled sex workers to take control of their own lives.

The project was based on community, group and individual level interventions. One of the main goals of the community level intervention was to politically advocate for a redefinition of prostitution as sex work. The group-level intervention was based on peer education; sex workers' peers worked closely with health professionals, and this activity

4 Personal communication Dr. Smarajit Jana, founder of the Sonagachi Project, November 13th, 2009

gave sex workers educators a better social status among their communities. The individual-level intervention was based on developing skills and competences for HIV prevention, but this was not the main objective of the project. It was more about the community's power, status, and stigma.[39]

The first components of the project were access to health care and peer education. Sex educators were trained in groups of 12 and they got a small stipend for their work. By 1997, there were 65 educators and seven coordinators. They started with a ratio of one peer educator to 50 sex workers, but the ratio now is 1:160.[40] As a result of the meetings and trainings, the Sonagachi sex workers –led by the peer educators- formed their own organization in 1995. The Usha Multipurpose Cooperative Society Ltd., a registered society, began offering financial services to sex workers such as bank loans, and savings support, as well as social services such as schooling for sex workers and their children. This organization has mobilized sex workers, becoming a social movement that advocates for their own rights.

The project was based on a clear understanding of sex workers' needs, without trying to eliminate sex work, but instead trying to make sex work a regulated industry, establishing mechanisms that can sustain safer practices in the long run. As a result, the project has kept the HIV prevalence rate among prostitutes in Sonagachi down to five percent, while in the rest of Calcutta the rate of HIV infection among sex workers appears to be about 11%.[41]

Finally, one of the most important features of the project is its sustainability. According to Rotheram-Borus and Duan, "the Sonagachi model suggests five basic components of sustainable interventions that we identify with the acronym CURES: (a) *cost effective*: economic vehicles must be identified to initiate and maintain support for the interventions over time; (b) *useful*: programs must be useful to the target population, the stakeholders, and the practitioners who must implement the program; (c) *realistic*: programs must be feasible to implement with the existing skills of the practitioners; (d) *evolving*: programs must evolve over time; and (e) *sustainable*: programs must have an ongoing funding stream and constituency within the community to achieve long-term results".[42]

100% condom use in Thailand

The Thai HIV/AIDS program is one of the few in the world that has had success at the national level.[43] It began in 1989 and it was nationally expanded in 1991. Condom use in brothels rose from 14% in 1989 to 94% in 1993.[44] The goal of the program was to increase condom use in Thailand's sex establishments to 100%. The program involved active participation and commitment from the government and from owners of sex establishments. Although sex work is still illegal in Thailand, the government defined sex work in this country in order to control sexual risks. The purpose of the project was to enforce condom use not only based on female sex workers' decision to use it or not, but also by getting institutional support to do so. Because losing business is one of the biggest concerns of madams, owners of businesses and sex workers, the program

achieved an agreement upon the requirement of using condoms. If clients refused to use them, service was not provided. In this program, condom use is enforced through a committee that can impose sanctions to the establishments that fail to follow the norm. Therefore, the basic key components of the program are the following: requiring sex workers to use condoms with all their clients; requiring the brothels to enforce and demand use of condoms; protecting sex workers from difficult clients; monitoring that brothels actually enforced the use of condoms; and punishing the brothels that do not comply with the norm, including closing down establishments.[45] The 100% condom program was also based on a massive campaign that as a result of the implementation, changed social norms toward unprotected relations with sex workers.

The transferability of 100% condom has been problematic, because the success of this program depended a great deal on the characteristics of Thai society's hierarchical structure and its political system, which combines a traditional monarchy with military authoritarian rule.[46] Based on these cultural and political values, the program was a success mainly because in Thailand, the strongest military and central authority made enforcement of the law possible. However, there are some cases where the 100% condom use program has been adapted successfully to other socio-cultural realities, as in the case of the Dominican Republic.

The Dominican Republic

The 100% condom use program was successfully tailored to The Dominican Republic socio- political context, achieving consistent use of condoms among female sex

workers. The intervention was implemented in 68 brothels in two cities. As a result of the project, reported consistent condom use with new clients in the past increased from 75.3% to 93.8%. As in Thailand, the program included significant support on the part of participants, including sex workers and establishment owners, for both government and establishment- based policies and support systems to promote and monitor the use of condoms within sex establishments. The intervention also included women's social mobilization, a strategy that was successfully implemented in the Sonagachi project.

The strategy in The Dominican Republic began with peer education in the 1980s, and after that, it implemented social marketing campaigns to promote the use of condoms. Finally, after the first national conference of sex workers organized by a local NGO in 1995, women got organized as Movimiento de Mujeres Unidas (Modemu).[47] Modemu became a union of FSW that supports HIV/STI reduction and women's rights advocacy.

In summary, this chapter analyzed the different theories behind HIV preventions strategies. Due to the limitations of behavioral change theories, the structural approach offer elements to design more comprehensive interventions for vulnerable populations. However, the implementation of programs based on structural approaches are challenging because they require deep transformations. The purpose of this report is to identify those structural conditions linked with a high prevalence of HIV in Honduras. In the following chapters, this report aims to complete a contextual analysis in order to determine how structural factors are operating at the country level in Honduras, and the causes of risk in

the specific population of female sex workers in the country. The ultimate goal of this report is to propose realistic strategies that integrate structural conditions associated with high levels of vulnerability to HIV among female sex workers in Honduras.

CHAPTER THREE: HONDURAS AND THE RISE OF HIV

Compared to the rest of the Latin American countries, Honduras has historically had a higher HIV incidence. Currently, Honduras represents 18% of the Central American population, while it reports 38.5% of the total cases in the region. Although the prevalence in the country has decreased to less than 1% (0.8%), HIV continues to be a problem for the most vulnerable populations in the country, because there are common structural conditions that increase individuals' risks. According to the structural approach, there are super-structural, structural, environmental and individual conditions that determine individuals' behavior. The current chapter is a diagnostic of the specific country's factors that make Honduras a place vulnerable to HIV.

Figure 2: Map of Honduras

HONDURAS: THE CONTEXT

Besides being the second poorest country in Central America, Honduras (Figure 2) is extremely politically unstable and economically dependent. Honduras has had a long history of military rule, and unlike other countries in Central America, during the 1980s, this country did not experience social revolutions, insurgencies or clandestine

guerrilla movements. In fact, Honduras was a key ally to the United States by supporting anti-Sandinista contras against the Marxist Nicaraguan Government, as well aiding the Salvadoran Government fight against leftist guerrillas. Besides its history of repression and political instability, natural disasters have plagued the countries' socio-economic state even more. In 1998, Hurricane Mitch nearly destroyed the country, killing about 5,600 people and causing approximately $2 billion dollars in damage.[48]

STRUCTURAL FACTORS THAT INCREASE VULNERABILITY AMONG POPULATIONS

As mentioned in the second chapter, the most common classification of structural determinants dealing with HIV transmission filter into three different categories: "(1) mobility due to migrations, seasonal work and social disruption due to war and political instability; (2) economic factors; and (3) gender inequalities."[5]

Political instability

Honduras' situation in 2009 has been very critical. Through the course of researching and writing this report, there has been an ongoing constitutional crisis which has placed the country under very unstable political conditions, in turn damaging the national economy, reducing the social cohesion of the society, and affecting the general well-being of Honduran citizens. Because of this crisis, violence has risen, while consensus and peace among citizens have decreased. Further, a severe polarization in the

5 This classification is based on Klein et al. (2002) Sweat & Denison (1998) offer a similar classification, but do not include gender inequality as a separate category.

society has resulted in serious tension within the country. The *de facto government* –as it is known- is not recognized by any country in the world as a legitimate institution. This illegitimacy has caused a decrease in international support and cooperation, thus shrinking the economy and reducing the budget for development projects.

Several organizations have denounced human rights violations. The International Federation for Human Rights (FIDH) confirmed that serious and systematic human rights violations took place after the coup.[6] These violations paired with the general political instability, increases both vulnerability among the already vulnerable populations and poverty, particularly among groups that obtain their income from informal activities of the economy. It also increases mobility within the country and overseas, which augments the risk of infection.

Mobility

Urbanization

Urbanization is frequently caused by the mobilization of young populations attempting to seek improved economic opportunities. Urbanization generally leads to family and social disruption and changes the environment in which people are accustomed to living. The current urban population of Honduras is 48% of the total population and has an annual rate of urbanization of 2.9%, the lowest it has been in fifty years (figure 3). Although currently the rural population is larger than the urban population, in the beginning of the 1960s the total urban population was 22.7%, (figure 4)

[6] The International Federation for Human Rights and other 18 organizations led a mission that took place from July 17th to 24th 2009 in order to assess the human rights situation in Honduras. Concerns over the human rights situation in Honduras after the coup d'Etat: FIDH participates in an assessment mission. http://www.fidh.org/IMG/article_PDF/Concerns-over-human-rights.pdf

this reflects a 50% increase in the urban population in the last fifty years. This sharp increase in the urban population translates into increased demands in housing, services, and employment needs of new inhabitants.

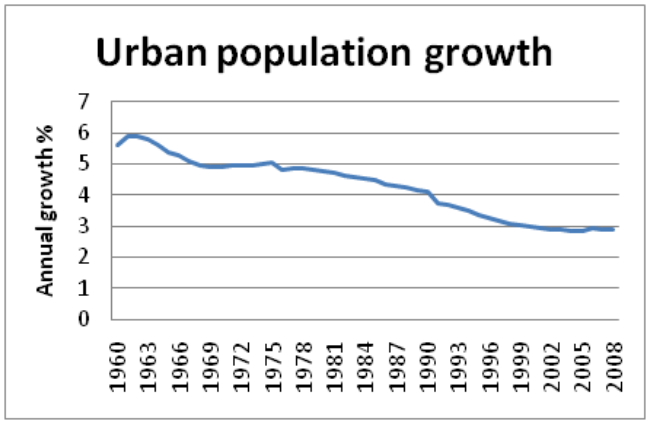

Figure 3: Urban population growth, Honduras 1960-2008
Source: World Bank, Word Development Indicators.

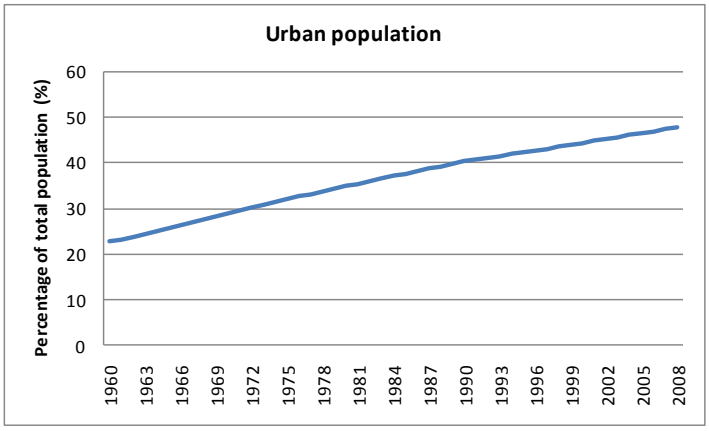

Figure 4 Urban Population growth, Honduras 1960-2008
Source: World Bank, Word Development Indicators.

Migrations

Migration has a significant economic and social impact on Hondurans' daily life. In 2004, with a total population of 6,702,291 inhabitants, approximately 700,000

Hondurans lived outside of their country. These migrants sent approximately $1 billion to family members residing in Honduras.[49] Remittances to Honduras are now the largest source of foreign exchange and direct foreign investment, exceeding total amounts of foreign aid assistance. Remittances account for 14% of Honduras' total GDP of $7.4 billion, and surpass income generated by the *maquila* textile and clothing industry (the largest source of GDP up until last year).[50] Today, close to one million Hondurans are living overseas, and this amount is estimated to increase considerably as a result of the political situation.

Economic conditions, poverty and level of development

Demographic statistics show that Honduras is highly vulnerable to the HIV epidemic because of its young population, high fertility rate, and relatively rapid population growth. Honduras has 7,792,854 inhabitants of which only 4% are older than 65 (figure 5); the median age of the total population is 20.3 years old (age in which most cases of HIV appear). A birth rate of 26.27 and a fertility rate of 3.27 indicate that the population growth is relatively high, at about 2%, factor that is according to a predominantly young population.

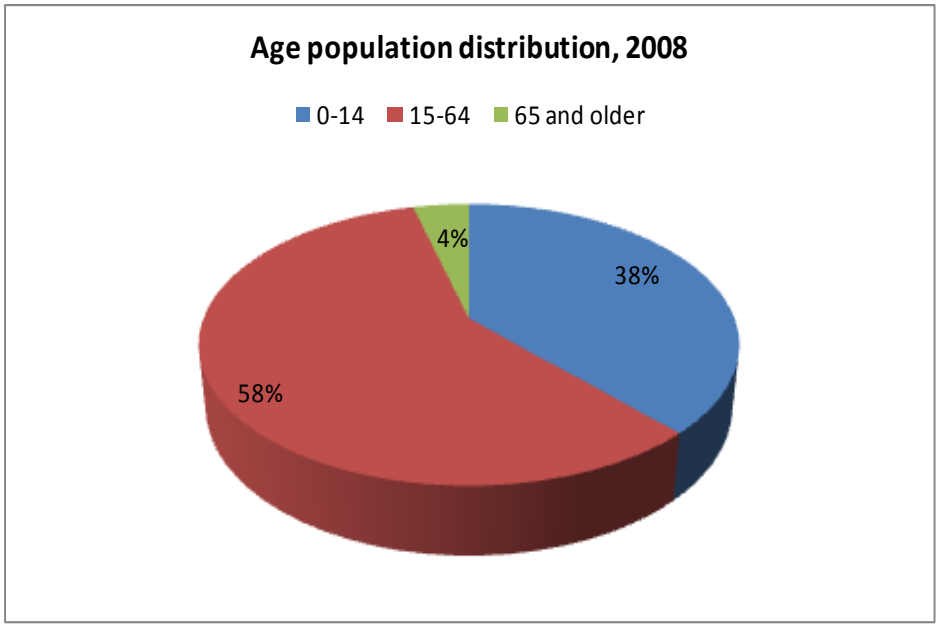

Figure 5: Distribution of the population by age
Source: Central Intelligence Agency, 2009

According to the World Bank (2009), Honduras is a lower middle income country, and the second poorest country in Central America, it has an extraordinarily unequal distribution of income and high unemployment. The social condition of the country indicates a high poverty and inequality level. In fact, Honduras is sixteenth in the world in terms of disparity within the distribution of income, showing a Gini index of 53.8 in 2003. Also, 50.7% of the population was below the poverty line in 2004.[51] The 2001 census showed that only 44.6% of total households did not lack in basic needs, which means that 54.4% had precarious living conditions, from which 11.7% lived in extreme conditions of poverty.

The term 'basic needs' refers to: crowding (17%), more than three persons per room living in a household, sanitation (32%), the household lacks an indoor flush toilet, subsistence capacity (21%), having four or more depending on one person who works and a household head with two or less years of primary schooling, education (11%), having a child between 6 and 12 years old who is not attending school; state dwelling (1%), living in a house made of irregular materials or rented quarters; and water (18%). When looking at unsatisfied needs by gender, it seems that women are better off than men. However, when looking at the number of people with three or more unsatisfied basic needs, women are worse off, which means that inequality is more severe in terms of extreme poverty conditions.

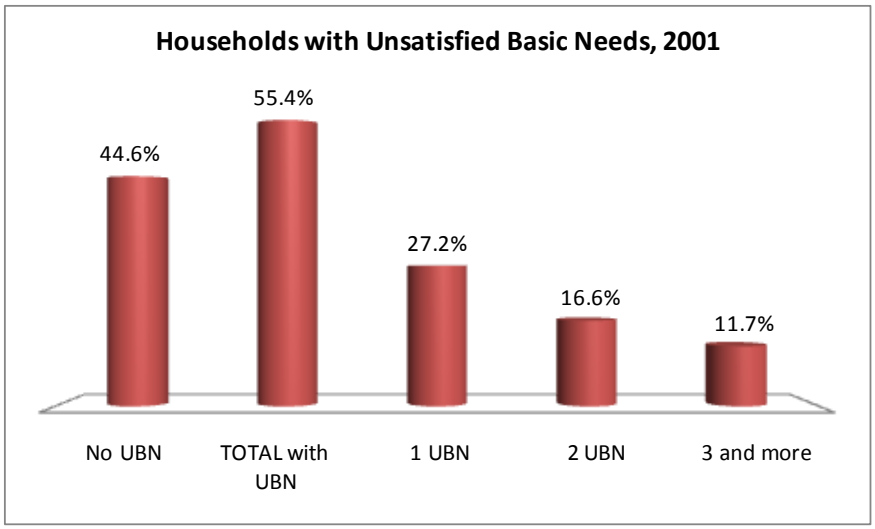

Figure 6: Total households with unsatisfied basic needs (UBN), Honduras, 2001

Source: National Institute of Statistic (INE), Census 2001

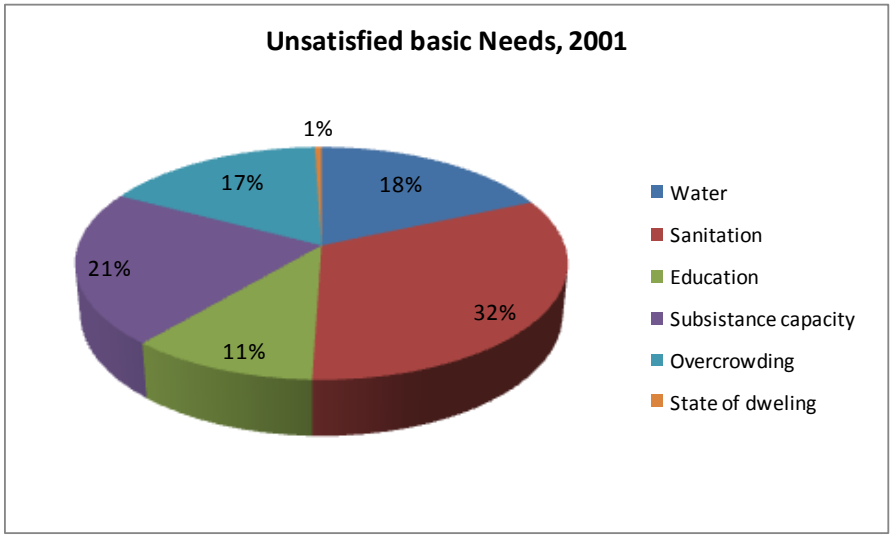

Figure 7: Type UBN from total households with unsatisfied basic needs, Honduras, 2001

Source: National Institute of Statistic (INE), Census 2001

The distribution of the gross domestic product (GDP) shows a trend towards a more diversified economy and less reliance on agricultural commodities (figure 8). This is in part a result of an increase in investment into the maquila and the non-traditional export sectors. However, a trend towards an economy specializing in services also reflects that a big proportion of the economy is based on informal activities, which are generally classified as part of the services sector. Indeed, the informal economy represented 49.6% of the GDP between 1999 and 2000.[52] Even though the unemployment rate was 3.5% in 2008, an expanded informal economy means that underemployment levels are high; a third of the labor force is seeking more work. With this weak economy, remittances represent over a quarter of GDP or nearly three-quarters of exports.

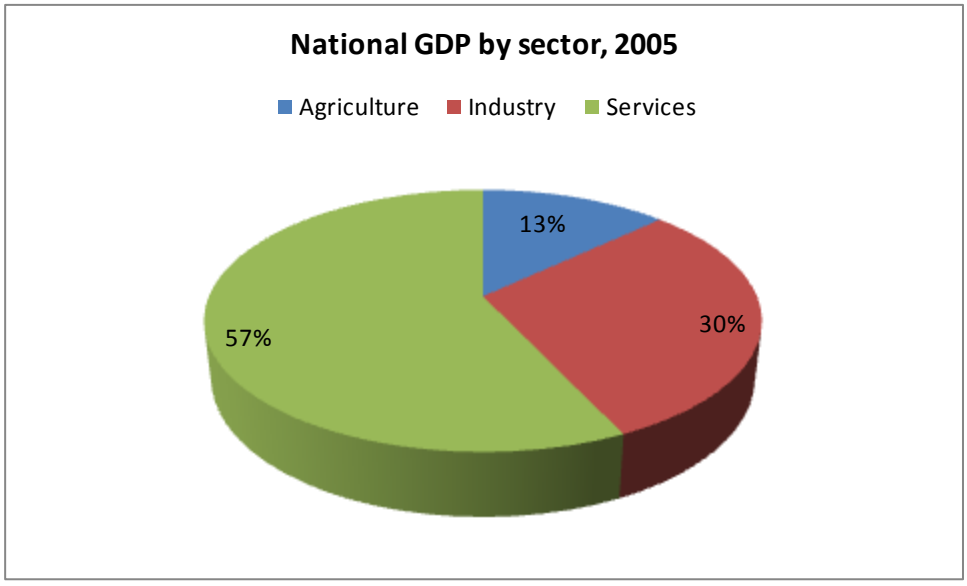

Figure 8: Number of people with three or more unsatisfied basic needs, Honduras, 2001

Source: World Bank social indicators

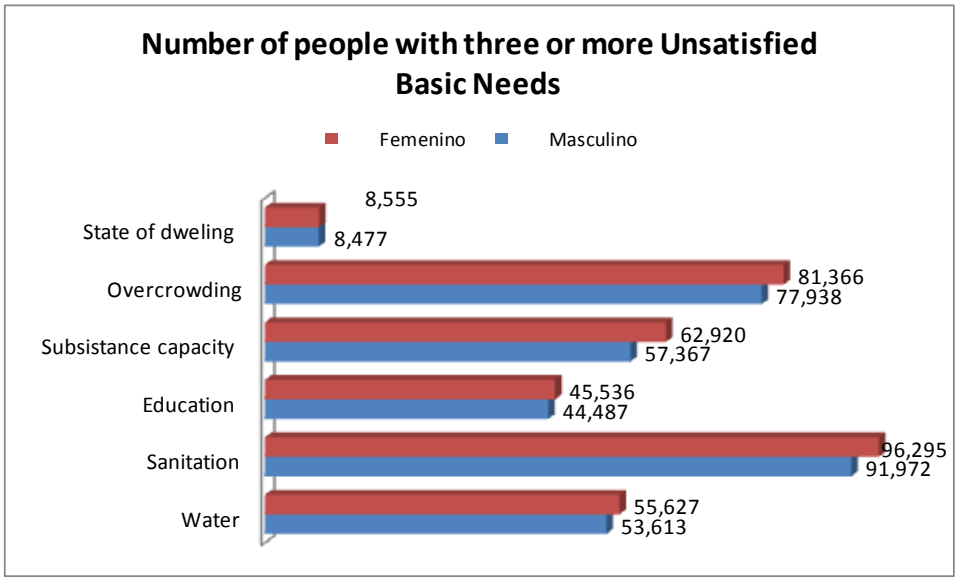

Figure 9: Number of people with three or more unsatisfied basic needs, Honduras, 2001

Source: National Institute of Statistic (INE), Census 2001

Gender Inequalities

In Honduran society there is high gender inequality, which is reflected in aspects such as: higher extreme poverty among women (figure 9), lower labor participation rate, lower literacy levels, and higher vulnerable employment.[7] Evaluations of the epidemic in the country have identified that gender inequality makes most of the female population vulnerable to HIV transmission.[53] According to the United Nations General Assembly, the reasons why women are more vulnerable to HIV transmission in Honduras are not only biological, but also economical, social, and cultural. Therefore, violence against women is a result of inequities existent among men and women and it is related to male dominance.[54] Machismo has been acknowledged as a manner of reproducing gender inequalities and a major obstacle for prevention strategies, such as the correct and consistent use of condoms. High levels of gender inequality are not only present in daily life, but they are also culturally accepted. Sexual and domestic violence against women are widely tolerated and accepted in the Honduran society, not only due to indifference, but also because of high levels of impunity.[55]

Even though women are acknowledged as a vulnerable population due in part to gender inequalities, it is important to realize that poverty increases the impact of gender inequality among women, that is, there exist important differences related to their socio-economic status. This fact is verified in the Family Health Epidemiological Survey

7 According to the World Bank Social indicators, in 2007 the labor participation rate of females was 36% while this rate was 80% for males; literacy rate for females was 83%, while it was 84% for males; and vulnerable employment for males was 49%, while it was 51% for females.

(ENESF-2001), which shows that while only 32.7% of women with a low level of education were aware of at least two ways of preventing HIV/AIDS, 76% of women with a high level of education have this knowledge.[56]

THE EPIDEMIC IN HONDURAS

Causes of the spread and high incidence

The first case of HIV in Honduras was detected in 1984, and it was reported by an inhabitant of Progreso, a city located in the northern coast of the country. The infection was associated with previous trips to San Francisco, California. After this incident, another four cases were reported among men; three of which were classified as homosexuals, all of them had traveled to the United States before contracting their illness. In 1992, an analysis of the first 100 cases of HIV in the country showed that 66% of the people who had acquired the virus were men, and 34% of them were women; which means a ratio of two men per one infected woman.[57] The majority of these cases corresponded to people between 26 and 30 years old. 62% of the total were identified as heterosexual transmission, and among them, 11 cases were female sexual workers. 61% of the heterosexuals reported to have had more than one sexual partner in the last five years. The other cases were as follows: 18 homosexuals, 15 bisexuals, 2 men who reported use of drugs, one case of blood transfusion, and two cases of mother to child vertical transmission. 67 of the total lived in the north coast, 34% in San Pedro Sula and 10% did not identify their residency.[58]

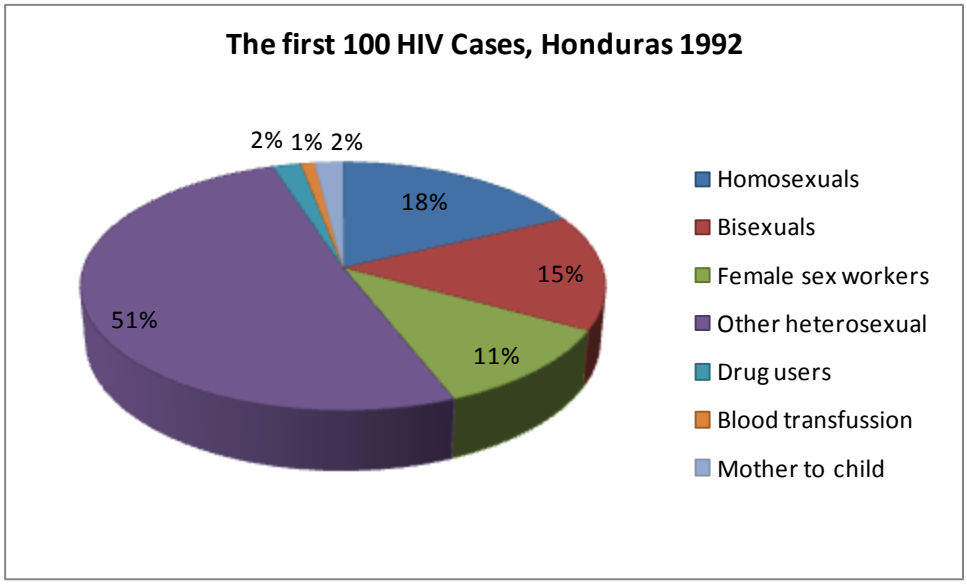

Figure 10: Analysis of the first 100 HIV cases in Honduras

Source: Garcia et al. 1998

According to the analysis of the first 100 cases, it is possible to determine the route of transmission through which the virus spread. Migration started as the first channel for homosexuals to acquire the virus, and then, probably bisexuals initiated the spread to the heterosexual communities. Besides migration, the creation of the Soto Cano Air Base was another historic key factor associated with the rapid spread of HIV, because of the large concentration of US troops and Honduran military. Palmerola, as it is known, was created with the purpose of supporting the Contras in the 1980s against Nicaraguan Sandinism.

According to Garcia O. et al., in the incubation period of the epidemic from the late 1970s and into the eighties, the social and political situation in Honduras was

different from the rest of Central America. In the eighties, Central America was characterized by strong social tensions that culminated with civil conflicts in Guatemala, El Salvador and Nicaragua. With the victory of Sandinism in Nicaragua, Central America and especially Honduras became a strategic area for the Cold War in America. A widely accepted theory in Honduras states that the strong presence of foreign troops in the country contributed to an increase in the number of adult entertainment establishments for soldiers causing increase in prostitution. As a consequence, there was a higher incidence of STIs in cities with military bases. This was the main route for spreading HIV in the general population. According to official reports, the annual incidence rate of gonorrhea increased from 143 cases per 100,000 inhabitants in 1979 to 196 cases in 1984. A similar increase also occurred in the annual incidence rate of syphilis, which went from 69 cases per 100,000 inhabitants in 1979 to 111 cases per 100,000 in 1984.[59] As a consequence, although the epidemic has been historically concentrated in certain groups, sex work had an important role in spreading the virus among the general population.

In 1998, although Honduras only held 17.4% of Central America's total population, it contained 51% of all HIV cases in the region (Table 1). As a result, in 2000, 10% of the general mortality rate in the country was attributable to AIDS.[60] On the other hand, in 1998 Belize (1.2%) and Nicaragua (1.1%), countries with similar development levels to Honduras, presented very low levels of HIV incidence.

Table 1: Cumulative number of HIV cases and deaths caused by AIDS in Central America March 31st 1998

Country	Total HIV Cases	Total deaths	Incidence relative Central America	Total population 1998
Honduras	8,217	1,081	51.6%	5,976,000
Guatemala	2,395	537	15.1%	10,715,000
El Salvador	2,019	289	12.7%	5,871,000
Panamá	1,620	993	10.2%	2,837,000
Costa Rica	1,284	674	8.1%	3,749,000
Belize	198	190	1.2%	239,000
Nicaragua	180	105	1.1%	4,933,000
Total	15,913	3,869	100%	34,320,000

Source: Garcia et al. 1998

Figure 11 indicates that HIV incidence in Honduras has decreased in present years, while in countries such as Guatemala and Belize the impact of the virus has increased. Other lower middle countries such as Nicaragua present historically low evidence, which can be related to differences in the political factors already discussed earlier in this chapter. Belize experienced a severe increase in HIV prevalence at the beginning of the 1990s, but after 1995 it stabilized at approximately 2%. Another important conclusion drawn from this graph is that at the beginning of the 1990s, the prevalence of HIV in Honduras was the highest among Central American countries, but after 1992, when it reached its peak, it began to decrease, and unfortunately this rate of decrease is slowing down. It is hard to determine the cause of this incidence reduction, because major changes are the result of incomplete available HIV surveillance data or weaknesses/changes in report systems.

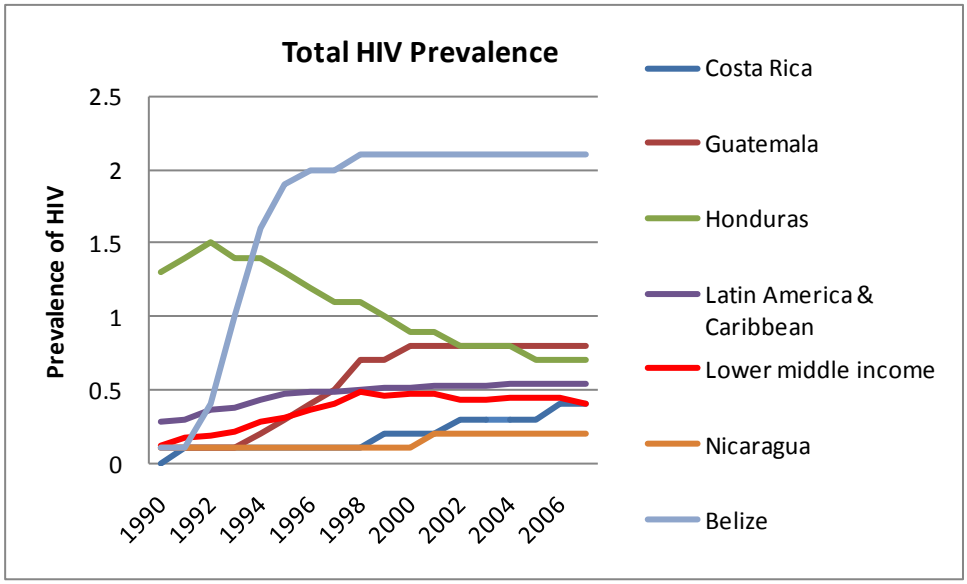

Figure 11: Comparative Historic HIV prevalence in Central America, Latin American and lower-middle income countries, 1990-2006
Source: World Bank, Social Indicators

The number of reported cases steadily increased in the 1980s until 1998, year in which statistics reported their highest peak. As shown in the graph, the national rate is characterized by fluctuations during the two decades. Changes in the epidemiological surveillance might be the cause of these variations. Including factors such as reduction of HIV tests, lack of human resources for notification, loss of data, and employee turnover are related to changes in the National System. Particularly since 2004, the epidemiological surveillance started a process of decentralization and systematization that has caused sub-notification in some regions.[61]

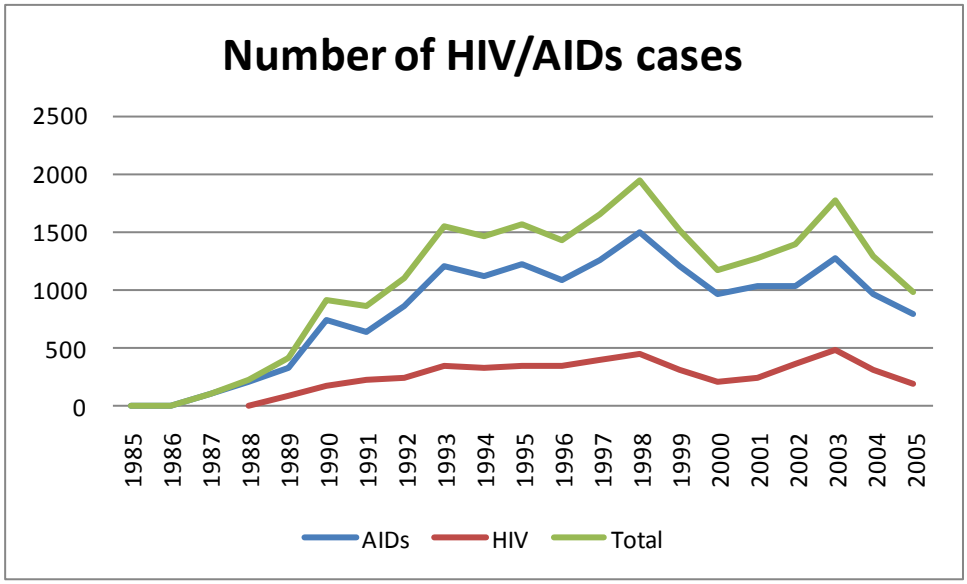

Figure 12: Number of HIV/AID's cases reported annually Honduras 1985-2005
Source: Department of STIs/HIV/AIDS, Secretary of Health, Honduras

THE NATIONAL RESPONSE

Honduras, as all other Central American countries, has organized a national response that aims to prevent transmission and provide care to people already infected by HIV. The national response to the HIV/AIDS epidemic has been led by the Ministry of Health, with collaboration from other ministries and several nongovernmental organizations (NGOs).

The process of planning and designing the national strategy began in 1989 when the Health Secretariat created The National AIDS Commission (COMSIDA). Between 1989 and 1994, the Secretary of Health also founded the National AIDS control Program (PNS); in 1999, the National Congress approved the Special Law on HIV/AIDS. This law

stipulated the creation of the National AIDS Committee (CONASIDA), the organization responsible for leading the response to the epidemic and promoting the defense of the human rights of people living with HIV (PLHIV) and those of the most vulnerable groups.

The Department of HIV/AIDS was created in the late 1980s within the office of the Secretary of Health, and the National AIDS Control Program was established in 1994 to coordinate national activities associated with HIV/AIDS. In 1999, the government established the National Commission on AIDS with representation from 15 national institutions in hopes of harmonizing the multi-sectoral response to the epidemic.

Between 1998 and 2002, Honduras implemented the first strategic plan called, PENSIDA I, with the participation of sectors from the government, civil society and donors, coordinated by the National AIDS Program. (Prevention of HIV and STIs immediately became a priority for PENSIDA I.) One of the purposes of PENSIDA I was preventing HIV and STIs. The impact of this plan was limited because it lacked coherence with the trends of the national epidemic. These weaknesses were mainly due to insufficient prioritization and cost-based analysis, and served as lessons for the organization to design a more comprehensive national strategy.

The second national AIDS strategic plan- PENSIDA II 2004–2007, was designed with the participation of government (49%) and civil society (51%). One of the goals of this plan was to promote sexual and reproductive health for HIV prevention. This second strategic plan also involved people living with HIV/AIDS. PENSIDA II focused on three

main issues: gender equity, human rights, and promotion of sexual and reproductive health. This plan prioritized 11 populations: adolescents, PLHIV, mothers and children affected by AIDS, the ethnic group garifunas, workers (especially from maquilas), sex workers, MSM, prisoners, orphan children affected by AIDS, children living in the streets, and mobile populations. PENSIDA II proved difficult to implement and evaluate, because most of the indicators established were not easily measureable. Four of the 10 indicators could not be evaluated because of lack of data and only two of the objectives were achieved. Limited national capacity to respond to the epidemic, inadequate information, lack of financial resources and insufficient coordination were some of the main weaknesses of PENSIDA II.[62]

The weaknesses of PENSIDA II were taken into account when designing the present National Strategy. PENSIDA III's (2008-2012) goal is to prioritize and focus financial resources and efforts, according to the trends of the epidemic, and boost the impact of interventions. PENSIDA III prioritizes interventions in five main groups: MSM, sex workers, prisoners, garifunas and people living with HIV.

The strategies designed in PENSIDA III aim mainly at providing care and treatment for people with AIDS, and prevention services provided for vulnerable populations to reduce HIV incidence in the country. Currently, an estimated 3,000 of 28,000 people living with HIV/AIDS receive care and antiretroviral treatment. Treatment is free to individuals who cannot afford it. Prevention strategies aim at universal coverage for highly vulnerable populations. Current HIV prevention efforts are based on the ABC

goals, that is, Abstinence, Being faithful, and Correct and consistent condom use. Interventions' are based on information, education and communication (IEC) strategies. The majority of these strategies are based upon peer education to induce behavioral change in order to reduce risk.

Distribution of financial resources invested in HIV

Figure 13 shows how the expenditures are distributed among different categories in the national response to the epidemic. Statistics taken from the graph show the majority of resources are invested on prevention (43%); care and treatment of PLHIV represent a lower percentage of expenditures (29%). This is logical, since the epidemic in Honduras is not generalized, but instead, it is concentrated among some vulnerable populations. Thus, prevention among these risky populations becomes a critical factor in reducing HIV incidence. Management of the programs represents almost the same percentage as care and treatment (26%), which implies a high cost of implementing the strategies.

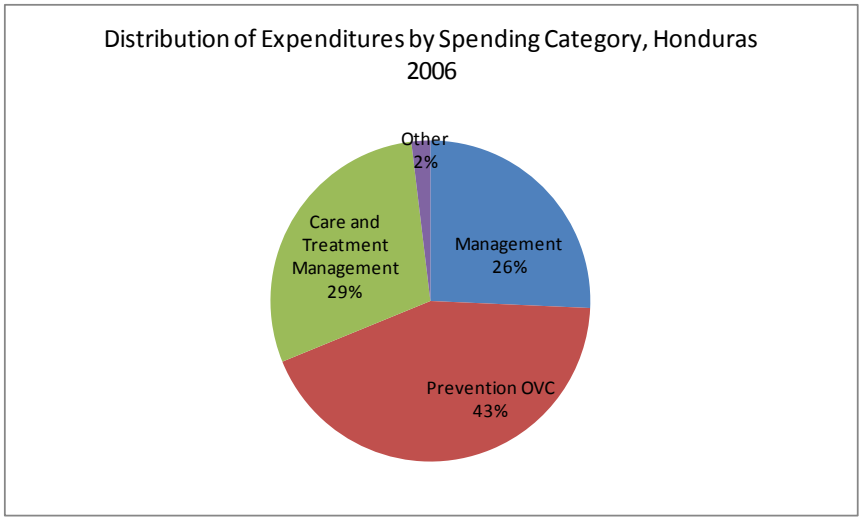

Figure 13: HIV/AIDS national distribution of Expenditures by spending category, Honduras, 2006
Source: UNAIDS, country indicators

The high cost of the response is worrisome when considering that the majority of the sources are coming from international cooperation (71%) (Figure 14), and these resources tend to reduce, especially in times of global economic crises. Since financial resources are scarce, in order to remain sustainable in the future, organizations should optimize interventions in a way that reduces management cost and reaches larger amounts of populations.

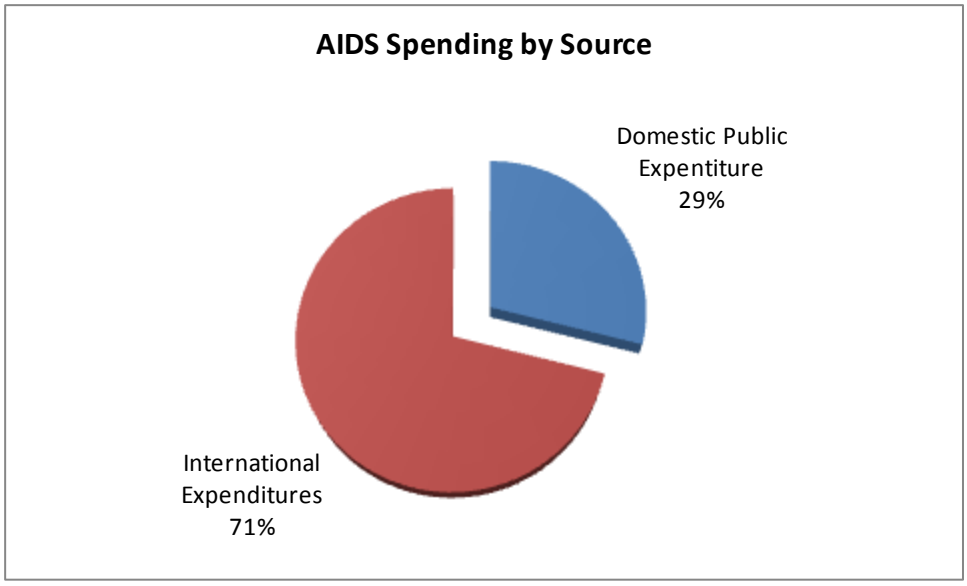

Figure 14: HIV/AIDS spending by source of funding, Honduras, 2006
Source: UNAIDS, country indicators

The financial resources allocated to HIV/AIDS in Honduras increased almost two and half times during the implementation of PENSIDA II. As a result, almost $89 million dollars were invested between 2003 and 2007. Donations from international cooperation rose sharply between 2003 and 2005 but began to decline in early 2006. National resources for HIV make up only 3% of total resources for HIV/AIDS in 2003, but they must reach 30% in 2007. In 2006, the total expenditures on HIV reached $14 million dollars, from which $4 million were funded by domestic public expenditures, and $10 million by international expenditures. Although more than 50% of the resources invested in HIV still come from external sources, figure 15 shows a trend towards a decrease of external resources invested in national health. This is a natural response to the reduction of the HIV incidences in the country.

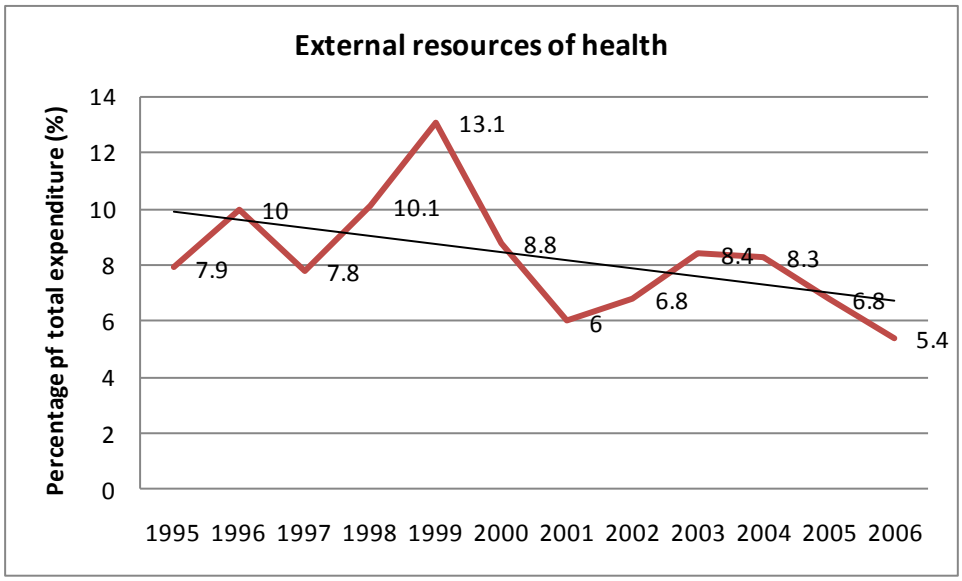

Figure 15: External resources for health as percentage of total expenditure on health, Honduras1995-2006
Source: WHO, country indicators

Figure 16 shows the route of new infections in 2007. According to this chart, there is very low incidence due to drug users (3%) and, although 19% of the new transmissions correspond to MSM, most of the new infections were due to heterosexual transmissions. The figure also shows that even though only 0.7% of the new infections corresponded to FSW, total infections related to sex work made up 29% of the total new infections. This percentage includes the incidence in FSW's clients (15%) and in their clients' partners (13%), suggesting that married men infected their wives or partners after visiting FSW.

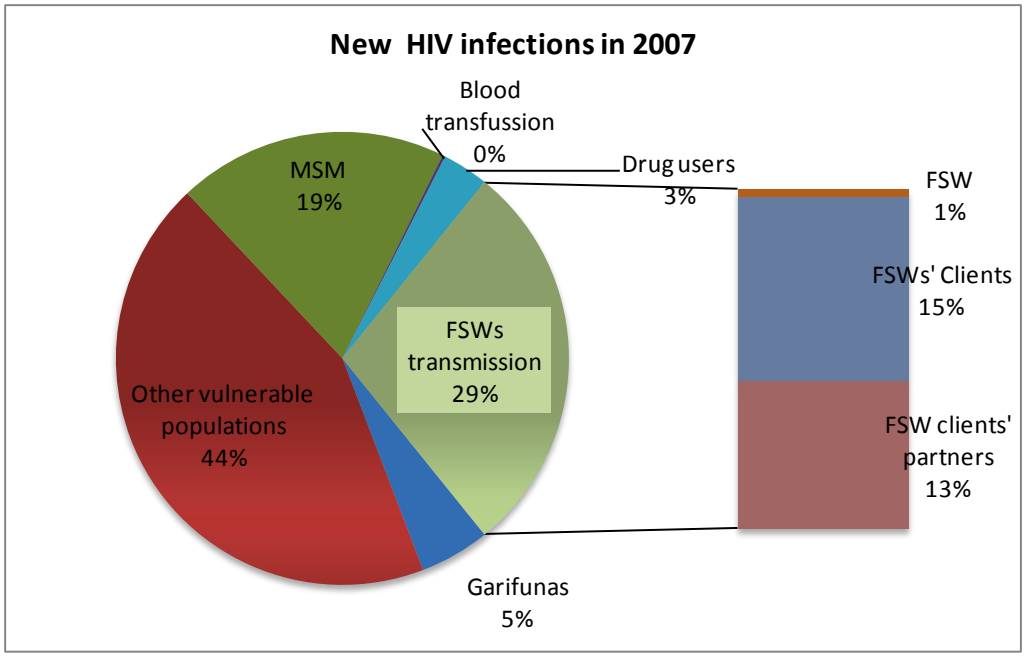

Figure 16: Routes of HIV transmission, Honduras, 2007
Source: Secretary of Health in Honduras, 2007

Figure 17 shows the way that distribution of prevention expenses in 2006. The highest priorities were for condom provision (28%), reduction of STIs (15%), counseling and testing (11%) and programs for youth out of school (11%). This distribution demonstrates a high priority of biomedical factors since strategies such as reduction of STIs and voluntary counseling and testing represent almost 40% of the total budget for prevention. Except for 2% allocated in community mobilization, the budget does not show other long-term prevention strategies. Only 4% was invested in programs for FSW and their clients

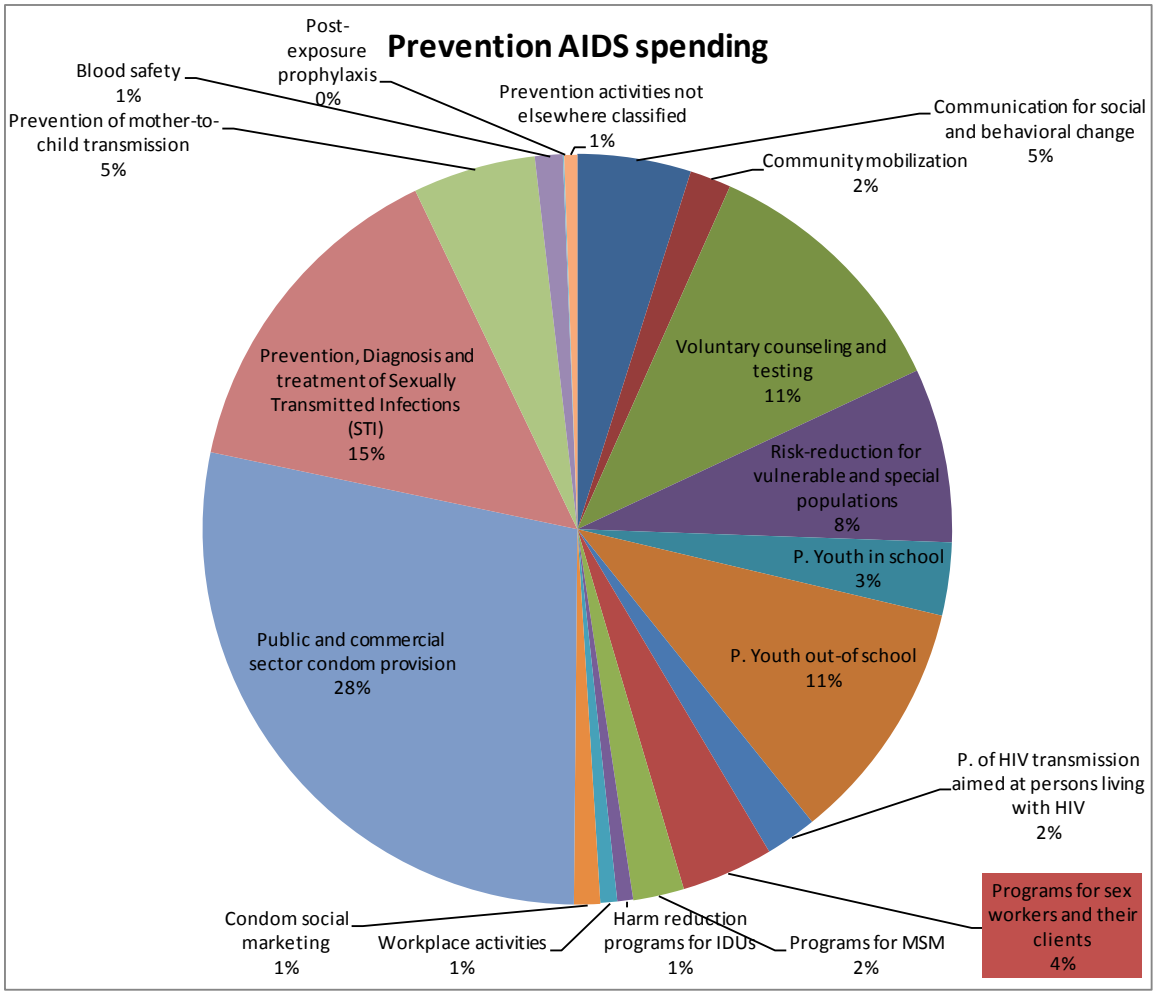

Figure 17: Budget distribution by type of intervention, Honduras, 2006
Source: WHO, country indicators

In summary, Honduras' diagnostic shows that there are some specific structural conditions that make the country vulnerable to HIV. Social disruption caused by migrations and political instability are main factors that increase the likelihood of exposure to HIV in the country. Political instability also facilitates the violation of human rights and exacerbates the socio-economic conditions of the poorest populations.

Inequality and specially gender inequality increase the vulnerability of women because it increases their economic dependence on men and reduces their ability to take control of their own lives. Although the trends of the epidemic show that HIV incidence is decreasing in the country, a large amount of resources are still focused on reducing HIV. These interventions are mainly based on behavioral change theories.

CHAPTER FOUR: SEX WORK AND HIV IN HONDURAS

High HIV incidence rates are mostly found in vulnerable populations that have constrained their ability to adopt healthy practices. Therefore, the purpose of this chapter is to identify whether or not there are structural conditions that increase female sex workers' vulnerability, and if these structural conditions constrain women's individual ability to make choices that promote their own health and protection. Based on this diagnostic of female sex workers' conditions, I will analyze if current prevention strategies address these structural factors.

METHODOLOGY

Limited information was available about sex work in Honduras. The documents available are related only to HIV and not to sex workers' conditions. Also, the data found about incidence of HIV among this population differ from one source to another; therefore, without reliable information, this report is based basically in primary sources. In order to analyze the structural conditions that influence sex work in Honduras, most of this section is based on qualitative research methods, primarily observation and interviews. This methodology and the proposal of this report were approved by the institutional review board (IRB) of the University of Texas at Austin on October 2009 (Appendix A). During the summer of 2009, I conducted fieldwork in which I had the opportunity to interview HIV experts in Honduras, as well as vulnerable, affected and

infected populations. I did about 80 semi-structured interviews, which I used to write a book called Huellas de Vida (Traces of Life), a publication that illustrates the impact of the interventions in prevention and care for those affected by and vulnerable to HIV in Honduras. The book compiles 12 stories of successful interventions of the program Strengthening the National Response for Promotion and Protection of Health in HIV/AIDS, financed by the Global Fund to Fight AIDS.[8] I used some information from one of the stories published in the book that is about HIV prevention strategies for female sex workers (Appendix B).

Some of the key informant interviewees of this report are members of organizations that have implemented programs targeting sex workers. The organizations are the following: Association of Medical Doctors of Asia (AMDA), Rimas Cultural Association (Rimas), the Center for Orientation and training in AIDS (COCSIDA), and the organization of Development Programs for Children and Women (Prodim). Other key interviewees were the director of a medical center that serves sex workers, and Carmen Fandino, coordinator of the organization of sex workers, Women United for the Control of STIs and HIV/AIDS, who besides being a former clandestine sex worker, has experience in prevention work with this population.

During this fieldwork, I had the opportunity to visit three brothels and nightclubs in Choluteca, a city in southern Honduras. In these places I conducted semi-structured

8 This fieldwork and the publication of Huellas de Vida were supported by CHF Honduras, an international NGO that is the main recipient and economic resource manager of programs for prevention and care for people with HIV, funded by the Global Fund to AIDS in Honduras.

interviews with eight sex workers and three managers of brothels, including two who besides managing the brothels, are also engaged in sex work. I also had the opportunity to participate in an informational workshop on STIs, HIV, and the correct use of condoms, with the participation of 22 clandestine female sex workers. This workshop was held in Amapala, a town located on the Pacific coast of Honduras. Both women from brothels and clandestine sex workers had participated in intervention programs implemented by AMDA and Rimas.

In a second phase of fieldwork, I conducted a questionnaire along with semi-structured interviews with 10 sex workers who work in the San Isidro market in Comayagüela city (Appendix C). These interviews were coordinated by Carmen Fandino and were carried out while the women were working. I also interviewed a former sex worker who discovered nine years ago that she had HIV. Finally, I conducted two semi-structured interviews with two sex workers involved in prevention projects implemented by COCSIDA in Tela, a town of 26,300 inhabitants located on the Atlantic coast. In total I interviewed 21 women who are currently engaged in sex work and three who are former sex workers.

CLASSIFICATION OF SEX WORK

It is estimated that 0.7% of all women between 15 and 49 years old are engaged in sex work in Honduras.[63] Thus, the approximate number of sex workers is between 13,283

and 14,000 women.[9] This estimate does not include all women who anonymously engage in this occupation. There are three kinds of sex workers in Honduras: the street-based, the brothel-based and the clandestine sex workers. While each of these categories implies some variation in the characteristics of sex work, they have common structural conditions that increase vulnerability of all female sex workers to HIV. The argument of this report is that these structural conditions must be taken into account for implementing effective and sustainable strategies that can make long term changes.

The following is a description of the different populations of sex workers and their differences.

Brothel-based sex workers

Brothel-based women work in an establishment that provides sex services. These establishments may be brothels or nightclubs. Women tend to live in brothels, while women who work in nightclubs are more volatile. In both of these places, usually, women pay a flat fee for every time they use a room. Because local government policies have been slowly closing the establishments in which sex work is offered, brothel-based sex workers are a minority in Honduras, and are located in the area of Choluteca. Although it is possible that some women suffer from exploitation by managers of nightclubs, in general, brothel-based workers are less vulnerable than those working on the street or underground.

9 According to the National Institute of Statistics, there were 1,786,391 women between 15 and 49 years old in 2000

Street-Based sex workers

Due to the closure of nightclubs and brothels, the number of women working in the streets has increased in the last two decades. In Tegucigalpa and Comayagüela, the two largest cities of Honduras, sex work is mostly practiced on the street. Most women are concentrated in the San Isidro Comayagüela market. While waiting for customers, many of them also work in the market selling vegetables or at stop lights selling candies and sodas. Some of them work during the day and others at night. Sex work is performed in hostels and clients usually pay for the room. Women prefer to have regular clients, but in the presence of new clients, they use their instincts to avoid being in risky situations. Because of the highly vulnerable conditions in which they work, street-based workers are organized in order to protect themselves and ensure that all the clients are required to use condoms. In Tegucigalpa, being organized has helped women to reduce their vulnerability. Nowadays for example, the police respect them and do not abuse them as they did in the past. Customers also have become accustomed to using condoms. However, street-based sex workers are still more likely to be discriminated against than other sex workers, because they work in public spaces and crowded places where they are socially recognized as prostitutes. This public recognition makes it harder for them to obtain a job outside the sex industry.

In the case of Tela, a tourist town located in the Atlantic coast of Honduras, women are placed in strategic locations such as the gas station or the roadside. The clients are truckers, taxi drivers, trailer drivers (who have room in the trailer), masons and

builders. Unlike Tegucigalpa and Choluteca, women are not working in the same place. This increases women's risks, because they are isolated trying to find their customers.

Clandestine Sex Workers

There are places in Honduras where, due to stigmatization and public policies against sex work, women have become clandestine sex workers. Some of them are former brothel-based sex workers in places where authorities have shut down establishments that used to provide sexual service. In other cases, women do not recognize themselves as sex workers, because they do not regularly work in this occupation, but they practice it when they need money or when they find clients. Working underground is not only motivated by women who do not want to acknowledge themselves as sex workers, but also by societies and communities where they live in that prefer to avoid and ignore the existence of sex work. Working underground allows communities to evade discussions and solutions about sex work. On the other hand, acceptance of sex service provisions requires regularization and recognition of this occupation. Sex work recognition is a difficult issue in the Honduran conservative and patriarchal society.

According to Edma Gabino, a volunteer in the HIV prevention project in Amapala -a major port on the Pacific coast- many of the clandestine sex workers practice this occupation, but they do so for supplemental income. "They do not always practice sex work, but they do it when they find a good client, who gives them 500 lempiras (US$1=18 lempiras). Some old ladies, who do not get support from their children, may

charge between 50 and 80 lempiras. Some pretty girls who are not regularly engaged in sex work may accept 2,000 lempiras from a man who wants to have sex with them."

STRUCTURAL FACTORS DETERMINING HIV VULNERABILITY OF SEX WORKERS

Several conditions increase women's vulnerability and exposure to sexual risks: domestic and sexual violence, large families and single parenthood, poverty and socio-economic conditions, and policies that reduce women's ability to protect their own health.

Violence and male domination

Through their lives, women must face male violence perpetuated from different actors and in different scenarios. Parents, uncles, police and clients dominate and abuse women in different scenarios, and in different ways such as, domestic or sexual violence. Most sex workers reported having suffered from physical and sexual violence. They reported physical abuse in their households or sexual abuse by family members when they were children. Street-based sex workers were more likely to speak openly about rape, and this fact was accepted as normal part of life, suggesting that in some ways, sexual violations have become socially accepted by the communities in which women live. Seven of the 10 street-based sex workers interviewed reported having been raped as children. Women reported being raped by uncles, brothers, cousins, husbands or even by

fathers, mostly when they were younger than 13 years old. Some reported several sexual violations by different people.

The following are some testimonies from women who suffered sexual abuse or physical violence as children:

> My grandmother beat me. Since I was 11, I grew up as a woman. My grandmother did not take me to school, or to study, or teach me how to read, or anything, just to work.
>
> Lorraine, 33

> I started working when I was 20 because I felt very disappointed and confused, I had no support. My brother was molesting me since I was 12 until I was 18. In my house nobody believed me when I told them that he harassed me, and my brother threatened me when I tried to say something. When I was 18 I decided to run away from my home. Then I got pregnant and lost my son, and then I decided to start working.
>
> Karen, 25

> I was raped several times. My uncle raped me three times: the first time when I was 7, the second time when I was 12, the third time when I was 14. I told my mom and she did not believe me. Then when I was 15, my cousin raped me. I got pregnant from him. When I was about to give birth, he kicked me and made me have an abortion. People were disgusted by me. I did not have a mother who supported me.
>
> The father of my children also abused me. I am afraid of him. He hit me and then raped me. I condemned the incident, but police said he could not rape me because he was my husband. So I put a machete to his head 6 months ago. I was going to kill him. He has not returned since then.
>
> Iris, 32

Sexual violations are part of women's daily lives, because rapes have been accepted by their mothers, grandmothers and other relatives in their households. For this reason, in most cases, violators are not punished by families, or communities. Partly because of this lack of social pressure, crimes remain unpunished by authorities. The impunity granted to violations related to sexual violence allows these crimes to occur again in new generations. The fact that Iris was raped when she was a child did not lead her to sex work. She became a sex worker because somebody raped her daughter. She tells the story of how she ended up as a sex worker:

> My family did not support me. I started working because my daughter was raped when she was 12. When I brought her to the clinic, I had no money, and the doctor told me that somehow I had to pay him. Then I paid him with sex; that was the only thing I had. My goal was to make her feel better. After that, I started doing drugs and working on the streets. I became part of the gangs so I could take revenge of the crime committed against my daughter.
>
> When I was selling my body, I felt that I avenged the man who raped my daughter. I condemned the incident, but authorities did not pay attention to me. I spent five years in drugs and prostitution.
>
> Iris, 32

The lack of family support and protection makes teenagers vulnerable to social breakdown, limiting the opportunities that the social environment can offer them. Rape and abuse greatly reduce the value that they feel for themselves and to their lives. Sexual violence becomes something of everyday life. Under these conditions, sex work becomes the only viable option for many women. The following is the testimony of Rosa, who is currently the manager of a brothel; she also works there as a sex worker:

> When I was 24, a lady helped me get into the business. Sometimes when there is severe physical abuse in families, this causes psychological harm to human beings. I never knew my parents, and I lived with strangers. So I left my house and got into a brothel.
>
> Rosa, 39

While sexual violence and family abuse are common causes that motivate women to enter sex work, once in the sex industry, violence becomes part of women's everyday life, because they are faced with abusive customers or corrupt police officers. Four of the 10 street-based sex workers, who were asked about workplace violence, said they had been battered by their clients, because clients did not want to use condoms, or they wanted to steal women's belongings.

> Once, a customer wanted to rob me at a hostel; he did not want to pay me and he took my money from my purse. Since that time I'm not going with any man who I don't know; only known clients.
>
> Glenda, 33

Women's abuse by police officers has been controlled due to an informal agreement that sex workers from the organization Women United for the Control of STIs and HIV/AIDS made with the police. However, women who have been practicing this occupation for more than three years in Tegucigalpa and Comayagüela recall violations in which the authorities were involved. Mercedes, a 75 year-old woman who discovered she had HIV nine years ago, remembers how the police, rather than protecting them, were a threat for them:

> If we did not let the police do something, they forced us, and if we rejected them, they beat us. They did not pay us for sex; we had to pay them to let us go. If we complained, they got us into jail. Then, we had nothing.
>
> Mercedes, 75

> In the past, police raped and detained women. The authority arrested them and in order to release them, the officer asked them for sex. Since 2006 this does not happen anymore; we've won this battle. Now police only send a small squad to monitor women. The police know that the board of Women United for the Control of STIs and HIV regulates and monitors women. We talked with the sheriff, and because of this agreement we are not concerned about violations and harassment by the authority anymore.
>
> Carmen Fandino, 49

Many children and single parenthood

Many of the women reported being alone and also expressed that when they had a husband, they did not need to work because men take care of the household economic needs. Of the 10 women who were specifically asked about marital status, seven of them said they did not have a partner, three said they did have a partner, but were not married; two of them had their husbands in jail, which means that women were essentially alone taking care of their own families.

Most women interviewed stated that they entered sex work as a way to take care of their children, because they were either single mothers, widowed or separated, or did not have the financial support of their husbands. In other cases, very young women enter sex work and start having children with different partners. Of the 10 women who had

children, two of them had two children each, five had between five and seven, and three had four children. Most women said the children's welfare was the main reason to continue working.

> I started working clandestinely and not wanting to accept that I was a sex worker. I spent 12 years working to support my five children. When I was married, I had no need to work, but my husband was unfaithful, and the only way I found to keep my children was become a sex worker.
>
> Carmen, 49

The abandonment of husbands caused by male migration to other countries is one reason that motivates women to enter and remain in sex work. Maritza, one of the workers at the brothel La Troca, located in Choluteca, pays 50 lempiras to Blanca -the manager and sister of the owner- every time she uses the room. Maritza started working in La Troca in 2006 when her husband traveled to the United States and left her alone with their four children. Currently, there are eight other women working in the brothel, two of them are currently pregnant and one just had a baby. At the time of writing, one woman was six months pregnant and still continues working in the brothel.

Women widowed, separated and single, responsible for several children, also feel pressured to enter sex work. Paola is 29 and works in Los Almendros, another brothel in Choluteca. Paola felt very vulnerable when she lost her husband. In that moment, she decided to become a sex worker:

> I have two children, I am a widow; two years ago my husband was killed. Before, when I had my husband, I worked in an American shop and earned very little. For

> a woman alone it is difficult to maintain two children without a husband. Two years ago I decided to work on this.

Other women are single mothers or have had several children from different men and none of them support the children. Mercedes, 75 years old, left sex work nine years ago when she discovered she had HIV:

> As a single mother of two children, I washed other people's clothes to support my family, but I didn't make enough money, so I came three times a week to the Comayagüela market to find a supplementary income through sex work.

Since she became ill, Mercedes sells vegetables in the market.

Maritza, 33, has seven children from different men and none of them support her financially. She is engaged in sex work three times a week and sometimes works as a maid. In the absence of a husband or partner, she must take care of seven children by herself.

Socio-economic conditions

Socio-economic conditions are also structural factors that lead women to sex work, and, once women are inside, keep them highly vulnerable to situations in which they take risks in order to ensure their families' subsistence. According to Lessa Medina, Coordinator of AMDA, "there are socio-cultural conditions of the population [female sex workers] that cannot be changed in the short term, but must be addressed in the long run, such as their low level of education and their precarious socioeconomic conditions. These conditions generate practices among them that increase the risk of HIV transmission."

Women with precarious socioeconomic conditions, for example, have unsatisfied basic needs that are more important than health protection, such as feeding their children. Also, poorest women are more likely to have less education and to accept machismo and sexual abuse more easily than more wealthy and more educated women. Machismo and unsatisfied basic needs can lead them to the inconsistent use of condoms.

Despite the difficult conditions faced by sex workers, sex work is often their best option for income, because most of them have very low levels of education. Of the 10 street-based female workers interviewed, only two said they knew how to read and write. Many of them would like to find another job, but all they can do is housework, so they could basically work as maids, but the payment they would receive in this occupation does not compare with the income they could obtain through sex work. Moreover, sex work, especially the clandestine and the street-based, offers flexibility for women who do not have to obey orders from a boss or to fulfill job requirements such as a work schedule. Because of this flexibility, many women practice sex work as a part-time job.

Five of the 10 women who were asked how often they practice sex work said they work every day, including Sundays, while the other five said they work three or four times a week, or rest on Sundays. Four of the 10 women reported having another activity such as selling vegetables in the market, or water and soda; others were maids. Six of the women were engaged in sex work as their only economic activity. The number of clients per day varies between two and seven, and they all work during the day and not during the night. Most charge between 100 and 70 lempiras, although one of the oldest said she

charges between 80 and 50 lempiras, and two of the youngest said they charge between 100 and 150 lempiras. This means that in the best-case scenario, a woman who works seven days a week and has five customers a day, who will each pay 100 lempiras, will make a monthly income of 10,500 lempiras, or 583 dollars. This is a good amount of money compared with the 3,000 lempiras that usually a full time maid earns (US$166). In the worst-case scenario, a woman who works three times a week and has two customers a day, who each pays 50 lempiras, will earn 900 lempiras per month or the equivalent of 50 dollars. It is not easy to predict how much a woman earns, especially due to political instability. Curfews and protests prevent mobility and restrict nighttime work. These factors severely affect the daily income of sex workers. Indeed, all the women interviewed acknowledged that the political situation has hampered their work, reducing the number of customers, forcing them to reduce their rates to get more customers.

Marta, one of the sex-workers from Comayagüela, is 38 years old and has four children. She works every day in the market as a sex worker, and she also sells gum and candy during fairs in her city. She has two or three clients per day, and each pays between 70 and 100 lempiras per meeting. She estimates that she earns a little more than 4,000 lempiras per month (US$220). Martha would like to find another job, but it is difficult to find a job that pays her better.

> We are never taken into account, because everybody says we are street-based sex workers. I would like to work only in sales, but the money is not enough. Furthermore, how can I find another job if I can't do anything, not even read and write?

Karen, 25, is a part-time sex worker too. She also works as a maid and she earns a monthly wage of 1,500 lempiras:

> That money is not enough for anything. Working as a sex worker only during the weekends, Friday, Saturday and Sunday I make 8,000 lempiras per month. Sometimes clients are not good, and then I make 1,500 lempiras per weekend.

Karen, like Martha, would like to not be a sex worker, but other economic activities provide her with minimum income compared to what she can earn as a sex worker.

Policies that increase vulnerability

Closure of institutions

The main policy of the government in relation to sex work has been to close establishments that provide sex services. According to Carmen Fandino, guide of sex workers, "the authorities closed three or four brothels per year in Tegucigalpa. In these four years the government has closed about 15 bars, and then the only option for women is to work on the street; and they become more vulnerable on the street because anything can happen in the street". According to Carmen, the person who decided to start closing all establishments was Cesar Castellanos, a mayor of Tegucigalpa, who on December 31, 1997 closed the establishments located in the former "red-light district" of Belen where there were night clubs, cantinas and brothels that offered sex services.

Many other towns and cities in Honduras have adopted similar policies. In Amapala, for example, sex work was banned in the 1990s. As expected, this policy did not eliminate either the supply or demand for sex work, but instead, it increased the

vulnerability of women who now practice sex work without any regulation that protects them from sexual violence. According to Amapala's doctor, Armando Salvador Carranza, the prohibition sent sex workers underground. Now, those who wish to have a sexual encounter go to La Coneja's house, a woman who, besides selling pineapple vinegar, rents rooms up to 10 lempiras. So when one of the more than 11,000 inhabitants of Amapala decides to use La Coneja's services, the common joke among Amapalinos is that he is going to buy vinegar.

Dealing with police

The women reported no current problems with the police. However, the following is the opinion of Javier Calix, Program Manager of Prodim:

> There have always been violations by the police, but from 2005 and 2006, the abuses have been reduced because police got in troubles due to denounces of human rights organizations. Nowadays, the authorities are indifferent to sex work.

Due to constant complaints about abuse by officers, in 2006, the organization Women United for the Control of STIs and HIV/AIDS, reached an agreement with the chief of Tegucigalpa's Police. Under this informal agreement, women must fulfill their medical checks and police must not commit abuses of power against them. Previous to this time, women suffered continual sexual and physical abuse by the police. When women did not have their health card, police arrested them and required them to pay a fine in order to be released. Because in many cases women had no money to pay, many of them were raped and battered by the police. Police still take them to jail if they do not

attend to their medical controls. Also, because the reduction of abuses has been the result of an informal agreement, policies can easily change according to the proprieties of individuals in charge. Women's rights violations can be easily accepted, since there is not a clear policy that punishes corrupted officers. Also, because stigma, discrimination and human rights violations are inter-related, society and sex workers themselves may wrongfully believe they deserve physical violence.

No authorization to work and the health card

The Health Ministry issues a health card to recognized sex workers, that is, all except the clandestine ones. Police usually require women to carry their health cards in order to work. Ana Guillen, the doctor in charge of the STIs clinic in Las Crucitas, the health center that provides medical services to sex workers in Tegucigalpa and Comayagüela, states that the health card women carry is not a work permit:

> In the past, they had a card that gave a report on sexually transmitted infections, but now what they have is only a card for appointments. Then, the card does not authorize them to work in the street, but it shows whether or not they go to their medical checkups. However, police do not understand this and if the women do not have their card signed, the police arrest them.

Sex workers are constantly required to go to the doctor, not with the purpose of taking care of themselves but with the goal of not harming others. According to Calix "the health card is against human rights, because the police use it as a mechanism to force women to attend their medical checkups. Instead of implementing threatening measures, it is necessary to find mechanisms that increase awareness of the importance of women's

health." Sex workers also consider the health card as a violation of the right to integral health care. The right to health care is very different than compulsive exams and tests that violate women's confidentiality and dignity.[64]

Access to prevention and health

In the past, police used violence to force women to go to their medical checkups. Nowadays, women are required to go periodically to their medical checkups, and if they do not comply with this law, police arrest them. To avoid being in prison, sex workers attend their medical checkups. In the past, health checkups were once a week, and at the time of writing, they are once a month. According to Carmen Fandino, women requested this change, because every time they have to go to the doctor, this means losing a day's work. In the medical center, women have access to HIV tests and condoms, as well as access to information about STIs and HIV prevention. Carmen said that the service is not free and that each medical appointment costs five lempiras. All women are required to go to the same health center in Tegucigalpa and Comayaguela, and most women report having good health services. In places where sex work is clandestinely practiced, women are not required to go to the doctor, therefore, they are less aware about use of condoms, HIV and STIs.

Inconsistent condom use

Most women use a condom all the time. However, there are four reasons why women do not use condoms: because there is a shortage of condoms, because the

customer offers to pay more, because the client rejects the use of condoms and physically abuse women, or because although the woman uses condoms with her clients, she does not do it with her stable partner. All 21 women I interviewed stated they use condoms with all clients but only four women said they did not use condoms with their partners. One woman said that sometimes she does not have condoms and for this reason, she does not use protection with her clients. All of them said they have access to condoms, especially through the health center, but most of the women stated they do not have access to enough condoms. However, according to Calix, "women have enough access to condoms, but the amount provided is low. This should be their motivation to go to the health center, but street-based women do not like to attend medical checkups. In the past, the United States provided Honduras with sufficient free condoms. During George Bush's administration, however, the policy changed, and access to condoms went from being free to be based on the concept of social marketing, which means women have to pay a little for the condoms. Condoms cost up to 5 lempiras, so the lack of free access should not be an excuse for not using condoms."

Women reported buying condoms in the hostels where they have sex. Each condom costs between two and three lempiras. Most women reported receiving from 30 to 50 condoms a month, depending on the availability in the health center. However, there are times when the health center does not have condoms, and then they have to buy them. Faced to women precarious economic conditions, insufficient access to condoms is an obvious reason for women's inconsistent use of condom. For example, a woman who

has only three customers per day and work seven days a week needs at least 84 condoms a month. If in the best cases, she receives 50 condoms from the health center and other organizations, she will have a shortage of 34 condoms; an amount that she will need to buy. If the cost of each condom is three lempiras, she will spend at least 100 lempiras a month in condoms, a considerable amount of money compared with women's monthly income.

The second reason for inconsistent use of condom is that clients offer them more money in order to have sex without condoms. All women admit that they constantly face this situation. Clients offer up to 1,000 lempiras in order to have sex without a condom (compared with 100 lempiras they offer for sex with condom), but they all expressed that if the customer offers so much money, it is probably because he is very ill, so it is not worth exposing themselves:

> Often customers give 2,000 or 3,000 lempiras for not using condoms, but I tell them that if they want to do it without condoms it's because they are sick. I speak clearly to them; I don't do anything without a condom.
>
> Karen, 25

The third reason why sex workers do not use condoms is because the client rejects the use of condoms and physically abuses them. Lorraine, 33, said that in 2006 a client abused her:

> I went with him to the room and he said, well, you look beautiful, and he asked me to do it without a condom. I didn't want to have sex without condom. Then, he hit me because I refused. I told him that he didn't need to pay me, but I begged

> him to use a condom. At the end, he neither paid me nor used a condom, and he also hit me. Since that day I don't go just with any customer.

Due to the vulnerability of women and the fact that they have had a life of domination and battering, their power to negotiate condoms is very low. Although prevention programs are based on the idea that women should use condoms, in many cases, it is the man who makes the decision to not use a condom, even against women's will.

The last reason for not using condoms is related to women's sentimental issues when they find a steady partner. Although women who have husbands claim to be less vulnerable economically, paradoxically, those who have a husband are more exposed to risks, because many of them do not use condoms with their partners, and in most cases, husbands are unfaithful. Lorraine is 33 and has six children, her husband is in jail and she thinks he is not faithful. She does not know when he will leave prison, because he was previously imprisoned for five years. She hopes to be able to break up with him when he gets out of prison, but she is in love with him. Sentimental reasons such as love, trust and commitment reduce sex workers' use of condoms. Therefore, women put themselves at high risks when they fall in love.

Maritza works in a brothel called La Troca. She charges almost all of her customers an average of 150 to 200 lempiras. The only person who she does not charge is a man who was her client, but who is now her husband. He neither pays her nor uses condoms with her. He persuaded her to not use protection with the argument that he

would not treat her "like if she were a prostitute." Although she believes he is not faithful to her, and despite having participated in 10 workshops about HIV, this 36-year-old woman decided not to use protection, as if HIV were not transmitted when people have sex for love:

> I came here [La Troca] and they told me I always had to use a condom, so I always use it. I do not use it with my partner though. I've been working here for three years, and I have been all the time with him. He is my husband. He does not come every day, because he works in the battalion. He started as one of my customers; he paid me for two years up to 600 lempiras, and then got involved. So he does not pay me anymore, but he does not take my money. I tell him that I have my work because of my children, not in order to support him, and he understands that. The children live with my mom, at Palenque. When I have money, I see them, but I send them money and food weekly. Palenque is very far away. When he is not working, he stays here.
> He is not faithful. The truth is that he cannot be, because I know that men are not faithful. But I tell him: I know you're with other women, but it's enough if you protect yourself, because I do not expect a nasty disease from you.

Maritza is not the only one taking this risk. In fact only 30% of female sex workers in Honduras use condoms with their steady partners. This practice has become a challenge that HIV prevention projects must face.

WOMEN ORGANIZED: A STRUCTURAL FACILITATOR

The analysis of women's conditions offers clarity about common structural factors that sex workers face during their lifetimes. Street-based, brothel-based and clandestine sex workers go through very similar conditions that put them in highly vulnerable situations. For most of them, sexual and domestic violence in their childhoods

is the beginning of a life full of battering and male domination. As a consequence of sexual violations many of them start having children with men who do not support them. Being a single mother and living in precarious socioeconomic conditions leave them no better option than becoming sex workers. Once they are inside the sex industry, male domination comes in the way of police harassment and abuse from their clients The public policies implemented by the Honduran government have being very harmful for sex work, increasing violations of women's rights and exposing them to higher risks.

However, sex workers do not only face negative conditions. Violations against sex workers' rights have decreased because women have become organized. The organization of Women United for the Control of STIs and HIV/AIDS began in 2000 with 75 women and at the time of writing has 575 women in the area of Choluteca and Tegucigalpa; the majority of them are street-based female sex workers. The organization was inspired by Tacones Altos (High Heels), a movement of female sex workers in Latin America. According to Carmen Fandino, the purpose of Women United for the Control of STIs and HIV/AIDS is to give recognition to women and organize them so they come together and become empowered; therefore, sex workers will be able to demand recognition and respect.

The organization has worked in HIV prevention and promotion of healthy behaviors, such as encouraging medical checks and health protection. These efforts, however, have not been fully integrated and supported by the organizations that implement HIV prevention programs. The organization is seeking legal recognition, but

to achieve it, they have to collect 20,000 lempiras (US$1,100), amount that they have not yet been able to collect. However, according to Cadix, the real reason for not achieving legal recognition is that "prostitution is not legal in Honduras, and this is why it is difficult that government recognizes an organization formed by sex workers. This lack of acknowledgment limits access to projects and funds."

Despite having no legal status, the organization has been working with the local government to be recognized as female sex workers rather than as prostitutes. The aim of this recognition is to reduce discrimination and stigmatization against this occupation. For this reason, women have worked to advocate for their rights and increase their visibility in the social and political scenario, in order to increase their power in decisions that affect them, such as how to address HIV prevention programs. Although their recognition has increased, women still are viewed as recipients of aid rather than as key actors in the design and implementation of policy interventions on the population of sex workers.

HIV PREVENTION PROGRAMS FOR SEX WORKERS

It is difficult to know the exact prevalence of HIV among sex workers in Honduras, because different sources provide different statistics. Also, they are based on methodologies that are not comparable. The various studies done by the Ministry of Health show that prevalence has declined, albeit inconsistently, so it is very possible that

the historical trend is not reliable due to changes in measurement methods from one study to another (figure 18).

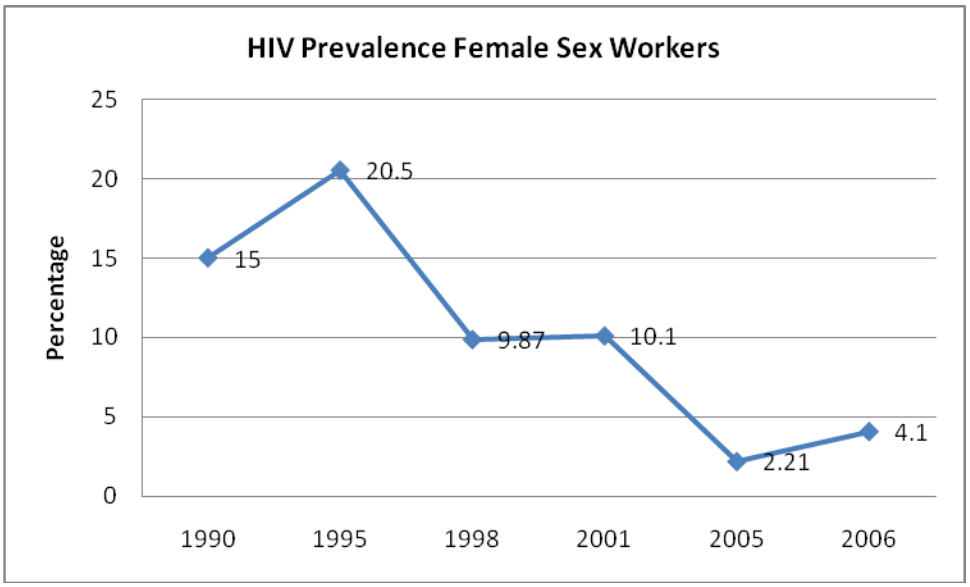

Figure 18: Historic trend of HIV prevalence among sex workers 1990-2006
Source: Secretary of Health, Honduras, 2007

Other studies outside Honduras show that HIV prevalence among female sex workers must be around 10%. The following graphic of UNAIDS, for example, shows a prevalence of 9.7% in Honduras, the highest in Latin America. The second country with the highest prevalence is Jamaica (9%), the third is Mexico (5.5%) and the fourth is Brazil (5%). UNAIDS results coincide with the study by Soto et al., according to which the prevalence in 2007 was 9.6%.[65]

Figure 19: HIV prevalence among female sex workers in selected countries in the world 2006
Source: UNAIDS, extracted from Elena Reynaga conference, Mexico, AIDS, 2008

According to the HIV Behavioral Surveillance Survey in Central America in 2006, 99% of sex workers know about HIV, the different ways of transmission and the use of condoms as a primary method of prevention. However, only 77% of sex workers consistently use condoms with new clients and 72% use it with regular customers. According to the Epidemiological Study of 2006, 66% of women reported condom use with their last client, and only 30% of sex workers reported condom use with their steady partners. Although since 2004 national prevention strategies have focused on sex workers, only 23% of sex workers (3,055) have had access to HIV prevention programs

and 21% correctly identify ways of preventing HIV transmission and reject major misconceptions about HIV transmission.

Saving Lives

The project Saving Lives is part of the program Strengthening the National Response to the Promotion and Protection of health in HIV/AIDS, funded by the Global Fund. This program is administered by CHF International and implemented by AMDA and Rimas. One of the objectives of the program is to promote and protect vulnerable populations through the adoption of healthy behaviors to reduce the risk of acquiring HIV. With this goal, the idea is to reach sex workers through a behavioral change communication (BCC) strategy that emphasizes face-to-face interactions, as well as to expand the coverage of the program's voluntary counseling and testing (VCT). From May 2008 to May 2014, the Program aims to provide preventive care and promote behavioral changes in 6,930 female sex workers. This amount represents approximately 50% of all sex workers in Honduras. AMDA/Rimas is going to intervene with half of the 6,930 women, and CEPROSAF, another NGO, is going to intervene with the other half located in the north of the country.

Saving Lives is a project implemented since 2004 with the goal of providing HIV prevention services to 18 year-old and older sex workers. Initially the project focused only on sex workers in brothels, but because many women sex workers were not in brothels, since 2009 the project began working with street-based and clandestine sex workers as well.

According to Denia Lopez, AMDA's Field Evaluator, the intervention has three different stages. The first is the socialization of the project with community leaders, the Ministry of Health, local governments and police. Under this strategy a main factor is the strengthening of partnerships of nightclubs and brothels' owners. This has ensured that the project reaches sex workers while they work.

The second stage is the intervention itself, which aims to promote healthy behaviors, based on the correct and consistent use of condoms. The intervention program lasts eight hours with each woman and consists of two workshops, each of four hours (eight hours total). The theme of the workshops is values, self esteem, human rights, STIs, modes of transmission, HIV prevention, and correct condom use. Correct use of condoms is based on three different techniques about how to put on the condom: using the mouth, the toes and having the eyes closed. This strategy has been successful because it has enabled women to acquire skills that are attractive to customers, encouraging women to use condoms without losing income nor reducing the number of customers. When the woman knows these new techniques, negotiating condom use is easier because the client shows less opposition to protection. The third phase of the project is to follow up with women who have been already participated in the workshops. After the eight-hour training, the project conducts follow-up visits with women in the brothels to bring them condoms and to find out whether or not there are new sex workers.

The project has indirect and informal interventions with clients and with the police. Johana Hernandez, Rimas' Field Worker, said that "police often commit human

rights violations against women, so when they come to the brothels, the project makes police officers aware of human rights respect. Project officials also speak with customers when they come to the brothels, to raise awareness about condom use."

According to Lessa Medina, AMDA's Coordinator, street-based and clandestine women are much more difficult to reach than brothel-based women. Through brothel-based women, the project reaches street-based and clandestine women. Street-based women are reached in the market, but doing so is difficult because they live in a closed environment that does not easily allow the entrance of strangers. Interventions with clandestine women are even more difficult. Many of the trainings are done in one of their houses. The following is the description Medina gives about workshops with underground sex workers: "the training is a mystery, because it is secretly done, preventing that the community from knowing that sex workers are in training. Women often enter the places where the training is developed through the back door so nobody sees them. This has been one of the major limitations, because we lack open access to women, making it difficult to work with their communities and their customers. Trainings are secret because we do not want the women to get more stigmatized and discriminated against their communities."

Besides the difficulty of reaching street-based and clandestine women, the project has other challenges. According to Johanna Hernández, "women's low level of education and income are important socio-cultural factors. Both low income and low educational levels are limiting factors for the promotion of condom use with clients, because there is

a strong demand for sex without condoms, which is also better paid. Due to women's low level of education, the project had to modify the visual material used in the workshops, making it more graphic, because there are many women who cannot read or write. Thus the project aims to make messages more clear."

According to Medina, another challenge of the project is working with clients and steady partners, especially in the case of street-based and clandestine women. Usually clients are people from the same community neighborhood of sex workers. In 2008, the project began trying to reach customers indirectly through anti-stigma massive events. Another challenge is the use of condoms with their partner. Medina says that "usually although sex workers' stable partners have other sexual partners, men reject the use of condoms with their wives; this has to do with socio-cultural aspects, because no use of condoms with their partners is a manifestation of love by the sex workers."

Analysis of the intervention

An analysis of the Saving Lives project suggests that the focus of interventions is to promote individual behavior changes in order to reduce the impact of HIV. This intervention strategy is based on face-to-face strategies, and it is reinforced in some cases by peer education. The project incorporates two basic objectives of prevention, the first is to increase the use of health services such as HIV tests and medical checkups, and the second is to increase access to condoms and information on methods for prevention and transmission of HIV. The goal of the project is to achieve the correct and consistent use of condoms. However, the success of the project is severely limited by structural factors

that determine the vulnerability of women to HIV. These factors are not systematically incorporated in the project. For example, condom use strategy ultimately relies on women's power to convince their partners and customers to use condoms. However, the bargaining power of women is limited by the fact that men are usually the decision makers. Also, sex workers' socio-economic conditions make them have higher priorities than protecting their own health, such as their children's subsistence.

Gender inequality is another structural condition that determines women's limited bargaining power. Therefore, in order to promote consistent use of condoms among female sex workers, a project should provide realistic tools that increase the bargaining power of women, as well as strategies that systematically work with clients and husbands to make men also responsible for the use of condoms. The responsibility for safer sex cannot rest exclusively on women because the decision whether to use condoms stems from a relationship of two people. Finally, the secrecy, stigma and police abuse are issues that the project should systematically address. The difficulty of reaching women is due to government policies that have made sex work an illegal practice punished by society, despite the fact that women could not be successful sex workers without men's demand. These policies increase women's vulnerability, so it is necessary to incorporate elements that actually transform the conditions under which women work. Police abuse cannot be tolerated and strategies must systematically promote respect for sex workers' rights.

Alejandra and Life

COCSIDA has implemented the project Alejandra and Life since 2005, with the aim of reducing the incidence of STIs, HIV and AIDS among street-based sex workers in the municipality of Tela, located on the Atlantic coast of Honduras. The project targets sex workers age 18 to 60 years old and it is funded by USAID.

According to Kenya Carcamo, Project Coordinator, "Alejandra was a sex worker who died of AIDS. She was a woman who had great knowledge about HIV and prevention methods. Despite having the information, Alejandra became infected from one of her customers. When she died in 2000, she left a legacy that information is not sufficient for sex workers to protect themselves. The project is named after Alejandra because it has a holistic approach. That is, it is not based only on the access to information as the fundamental motivator of behavior change."

The project is based on the Stages of Change Model, a theory of behavioral change that identifies the stages at which change occurs and the factors necessary to achieve it. This theory is based on the idea that information, education, and knowledge are not sufficient for change, but also require tools and beliefs to put knowledge into practice. The specific objectives of the project are to increase correct and consistent use of condoms and to increase access to voluntary HIV testing. The intervention takes place in small groups. COCSIDA intervened with 15 women first, then 45, then 60, and it has now reached 75 women. Each one of them is responsible for conducting all the interventions with a friend. This means that peer education has allowed face to-face

interventions with 150 women. The program also has a strong component of home visits to sex workers and their steady partners.

According to Maria Teresa Gonzales de Andrade, Executive Director of COCSIDA in La Ceiba, a town also located on the Atlantic coast of Honduras, COCSIDA is implementing an intervention based on access to information and voluntary HIV tests. "The project in Tela seeks to provide a more holistic approach. In La Ceiba, the program is over 12 years old and it focuses on larger groups. So far the project has involved 400 women, but without achieving any real behavioral change. For this reason, the idea of Alejandra and Life is to focus on women's self-worth to reduce stigma, not only on the use of condoms."

Alejandra and Life is based on the following three main strategies: The first strategy is behavioral change communication (BCC). Some project activities with this goal are facilitators training workshops, home visits, educational evenings, craft workshops and recreational-educational workshops. The themes of these activities are aimed at improving self-esteem, strengthening women's reproductive rights through the consistent use of condoms, and prompting leadership development, organization of women's groups, and participation. As part of this component of BCC, women also receive lessons in how to read and write.

The second strategy is the system of promotion and assistance to condom distribution. The project ensures free distribution of condoms to sex workers by systematically providing condoms in their workplaces, such as bars, hostels, restaurants

and billiards. Free access to condoms has allowed the increase of knowledge about their proper use.

The third strategy is the prevention of STI/HIV. This strategy is implemented in the clinic located in COCSIDA, and it aims to detect STIs early, as well as to administer HIV testing and counseling. The clinic has provided direct health care access to women and their clients. This has allowed an increase in the demand for health services and early detection of STIs.

According to Maria Teresa Gonzales de Andrade, although it is evident that through the project has influenced acceptance and condom use with partners, maintaining the third phase of the project will require more effort. "The problem is that international organizations define the approach of interventions. We [COCSIDA] want to know whether we are on the right track to generating sustainable changes in women. Actually people are adopting and maintaining new attitudes and skills that contribute to reduced levels of risk of STI/HIV/AIDS. Is the project actually producing behavioral changes among the sex workers?"

Analysis of the intervention

The project Alejandra and life is based on a comprehensive approach to HIV prevention in sex workers. The project has produced important behavioral changes in women, including the increase in use of condoms between sex workers and their clients and stable partners. The project has other important consequences such as self-recognition of women and their self worth as human beings. As a result of all activities

with sex workers, their families and customers, the project has increased the sense of community, which has enabled women to be less isolated. This community recognition has reduced sex workers' vulnerability, which in turns has increased women's power to negotiate use of condom use.

Despite the positive impact that Alejandra and Life has had in Tela's sex workers, the effects of this project are restricted because they require large investments of time and resources, and have limited ability to reach large populations. The project implements various activities that are designed to provide individualized mentoring to women at different stages of their behavior change. Therefore, the intervention requires large investments of time and human and financial resources. Due to the complexity of the stages of change, the human resources involved should be specifically trained in the methodology of the project. This is not always possible because it is difficult to find enough qualified staff. The assumption is that deep and individualized interventions undertake sustained changes in women's sexual practices. The individualized approach of the project and its face-to-face interventions undermine its capacity to make changes in large groups of the population. In four years, the project has only reached 75 women directly and 75 through peer education interventions. According to Kenia Carcamo, Project Coordinator, 150 women is not even close to be the total population of sex workers in Tela. Besides being a costly strategy and with limited scope, the impact of the project depends heavily on COCSIDA's mentoring of women. Therefore, it is likely that behavioral changes are unsustainable without COCSIDA's ongoing support. That is, it

could be that without the project, women will feel again vulnerable, increasing the chances of acquiring HIV. There may be exceptions, but they will depend on individual woman's ability to sustain her own behavior change.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

Practically worldwide, the majority of current prevention strategies are based on individual behavioral changes and focused on access to information, education and communication (IEC) as essential tools individuals should utilize in order to avoid or reduce risk. However, high vulnerability to HIV among certain populations is also determined by structural conditions beyond individual choices and behaviors. Prevention strategies with a larger impact, higher cost-effectiveness and greater sustainability have incorporated structural conditions undertaking systematic reductions of risk and vulnerability among populations.

A structural approach to prevention has been successfully implemented to reduce HIV prevalence among sex workers in a handful of developing countries. 100% Condom Use, a program introduced by the Thai government and replicated by the Dominican Republic, reduced the vulnerability of sex workers providing them with legal and institutional support and mandating condom use in all brothels. The Thai government imposed sanctions on brothels that violated this regulation. With the application of this program, condom use no longer depended on the woman's ability to negotiate protection. 100% Condom Use uses a top-down strategy, which means it is a national program imposed by the government. This solution requires a strong government with the ability and willingness to nationally regulate the sex industry. The transferability of this program

to the Honduran context would be restricted, since currently Honduras has almost become a failed state.

The Sonagachi Project also has a structural approach that seeks to reduce conditions of risk and vulnerability among sex workers in India. Unlike the 100% Condom Use, the Sonagachi Project is a community-led intervention; therefore, women's participation has proven to be an essential factor in designing and implementing the project. [10] Indeed, at the time of writing (late 2009), the program is fully implemented by sex workers in India. To reduce the vulnerability of women, the project provides environmental conditions that promote gender equality and sex workers' dignity and self-worth by combating discrimination against sex work. The project systematically addresses other components to reduce women's vulnerability such as economic security, women's and children's education, and customers' commitment to the consistent use of condoms. The experience of this project provides important lessons on how to implement prevention programs that seek to reduce the vulnerability of sex workers to HIV.

An analysis of Honduras' context offers insights about the structural factors that led to the rise of HIV in this country. The structural factors explaining the high vulnerability to HIV of certain populations are the following: political instability, high mobility, poor socio-economic, and gender inequality. The national response to HIV in Honduras recognizes that these conditions increase the risk of populations, but it fails when designing and implementing strategies that systematically incorporate them.

[10] Personal communication Dr. Smarajit Jana, founder of the Sonagachi Project, November 13th, 2009

The diagnosis of sex work in Honduras shows that there are also structural factors that increase the vulnerability of sex workers to HIV. Many conditions are linked to gender inequality such as: violence and male domination, size and composition of households, and poverty and socio-economic conditions. Another set of conditions increasing women's vulnerability are related to policies against sex work that are systematically violating women's rights, seen in the closure of brothels, police abuse and compulsory health practices.

The analysis of HIV prevention projects for sex workers in Honduras shows that interventions are based on theories of behavioral change and do not incorporate the conditions that make women vulnerable to HIV. For these reasons interventions have serious limitations. First, information, education and communication strategies are restricted by women's low educational level, which hinders women's understanding of HIV subjects. Second, obstruction of the behavioral change approach assumes that women have the power to decide on the use of condoms. However, women's bargaining power is limited by machismo weakening their ability to protect themselves. Thus, these interventions hand sex workers the entire responsibility of introducing condoms while on the job. Third, physical and sexual violence causes low self-esteem. As a consequence, self-protection and self-care are not sex workers' major concerns. In addition, women's living conditions determine that their priorities are focused on basic needs fulfillment (such as food and education for children) and not on HIV transmission.

Finally, policies against sex work present obstacles for organizations attempting to reach out to these women. These policies increase underground work and worsen the conditions where sex work is practiced. Besides being limited by not systematically incorporating the factors causing vulnerability, the interventions are based on individual strategies and face-to-face methodologies that have limited scope, because they involve reaching individuals one by one. Moreover, these interventions are costly, because they do not generate real transformations that achieve a reduction in the incidence of HIV among sex workers. In other words, they are ineffective and unlikely to sustainable. Even when women achieve significant behavioral changes, if prevention strategies do not systematically route factors such as sexual and physical violence, poor socioeconomic conditions, and state violence against sex workers, these structural conditions will always increase vulnerability and the prevention strategies will fail.

POLICY RECOMMENDATIONS

The following recommendations are based on the contextual analysis of sex workers' realities and needs. The aim of these recommendations is to provide guidelines on how to integrate structural factors that cause women's vulnerability into prevention programs. These recommendations are based on the identified structural conditions of sex work in Honduras, but also on the successful practices from other countries. I believe that especially the Sonagachi project has several components that are transferable to the case of Honduras. The following section follows the same structure as chapter four, that is, I

am going to give one recommendation addressing each of the factors determining the vulnerability of sex workers in Honduras.

Zero tolerance for violence, improvement of law enforcement and access to legal services

Women's testimonies show that many of them have entered the sex industry in reaction to rape in their childhoods. These violations have not been punished by authorities, nor condemned by families or communities. For this reason, prevention of HIV must condemn the widespread rape of women and all of the systematic violence against them. Therefore, one of the policies of intervention should be zero tolerance for any type of violence and violation of human rights against women. Another component that should be included in all HIV prevention programs are strategies that advocate for stricter penalties, prosecution and punishment of violators. Also, any kind of state violence against sex workers should be condemned. Thus, programs must establish clear mechanisms of pressure and punishment to police abuse. Organizations of women and clients can support these mechanisms by carrying out social control to reduce physical and sexual violence.

Another important element of this recommendation is to increase the number of complaints brought by communities about sex crimes and other type of gender crimes. This strategy should also include access to legal services for sex workers allowing them to report crimes which clients, husbands and authorities commit.

Access to financial services

Women with large families, who are the lone supporters of their children, are more vulnerable to HIV. Women are more likely to take greater risks motivated by their precarious economic conditions, such as having sex without a condom because the client pays more money. Thus, prevention programs should include a component for economic support, giving priority to single mothers and their families. Usha, the sex workers' cooperative in India, is a good example of an organization that provides access to credit, savings and other financial services to sex workers.

Access to education

The analysis of women's socio-economic conditions shows that low education is one of the factors that cause women to lack income opportunities outside the sex industry. This dependence on sex work increases the likelihood that women will accept poor work conditions, as well as abuses and mistreatments; because they do not have other possibilities. Many women would like to leave sex work, and argue that they do not do it, because they have no other job skills than housework. The lack of other skills reinforces their poor self-image and keeps their self-esteem low. Thus, HIV prevention should include an education component for sex workers and their children. Sonagachi incorporated a literacy program that was initially supported by volunteers, but as more and more sex workers learned to read, peer educators taught other women and their children.

The purpose of the education component will help women to acquire skills that provide them other income generating opportunities. The education component will also improve children's conditions of life and strengthen sex workers' self-esteem. Education will definitely increase women's power to negotiate the use of condoms.

Decriminalization and regularization of sex work

State policies against sex work, that at the same time allow the existence of the sex industry, increase the vulnerability of women and hinder the work of the organizations that implement prevention strategies. Prevention programs must incorporate political work to push the adoption of policies that decriminalize sex work. Decriminalization does not entail legalization, but it requires abolition of criminal penalties to sex workers, producing also changes in social and moral views on sex work. The objective of this component is gaining acceptance and regularization of sex work, in order to improve working conditions for women. To implement this component, programs must create a social movement that promotes an open discussion about sex work that involves sex workers, the media, academics, community leaders, students, politicians and health professionals, among others. The issue of sex work should be put on the political agenda as an issue of human rights, gender equality, and HIV prevention. These open discussions on sex work will encourage greater social acceptance of the subject, which will reduce the stigma and discrimination against sex workers. By making sex work a public issue, there will be more exercise of social control that will entail

greater political pressure for the design and implementation of policies that respect sex workers' rights.

Based on these political interventions, it is necessary to evaluate current policies and demand clarity about the government's stance on sex work. Social mobilization will aim at pushing the government to recognize sex work as an occupation, establish a legal framework and define standards that regulate sex industry. Policies should define the institution which is responsible for sex work regulation, because at time of writing, there is no clarity whether the Secretary of Health or Police should carry out control of sex workers. This assigned institution should be responsible for defining and enforcing minimum standards for sex work practice.

Based on sex work decriminalization, policies should strongly criminalize sexual crimes such as exploitation and trafficking, including crimes against children.

Relax the requirement for mandatory checkups and provide more integrated health provisions

Disease control policies and compulsory medical checkups represent violations against women's human rights and do not promote a comprehensive view of health care and disease prevention. Therefore, the current "health card" should be replaced by a mechanism that motivates women to use health services. The Sonagachi project improved knowledge of STDs and condom protection from STD and HIV. Health care provision was part of a comprehensive prevention strategy, framing HIV/STDs as threats to the

livelihoods and health of the whole community. In order to increase the use of health services by sex workers and their clients, sex workers were hired and trained as peer educators, condom social marketers, and eventually as supervisors and program coordinators. This strategy improved the community's ownership of the project and increased clients and women's utilization of health care services.

Another example of a successful health intervention is implemented in Nicaragua. In this country, the Central American Health Institute provides sex workers and their clients with health vouchers in order to improve the quality, efficiency and equity of health services to reduce STIs.[66] The voucher gives women the right to receive comprehensive health services aimed at prevention, timely detection and cure of any STIs. This service is free and covers the gynecology clinic, laboratory tests, medication, educational materials and some specialized procedures. The sex worker is free to choose the clinic (private or state) of their choice from a pre-selected list, in addition, women have full freedom to use their vouchers or not.

In order to improve health services utilization by sex worker in Honduras, current provisions should be evaluated in order to incorporate health care as an integral part of a prevention policy that promotes women's wellbeing, respecting their human rights.

Structural support to consistent use of condoms

One shortcoming of prevention programs is that they do not provide sufficient access to condoms. Because each woman requires a different amount of condoms

according to their number of customers and days worked, the supply and demand for condoms should be linked. As in the Sonagachi project, condoms can be sold, at a subsidized rate, rather than being freely distributed, and these small profits can be reinvested in the program.

In Honduras, there are two strategies that are actually promoting condom use. The first one is the informal agreement that street-based sex workers made in Tegucigalpa and Comayaguela to use condoms with all clients and not to provide services to clients who are willing to pay more for having sex without condoms. Second, AMDA and Rimas have increased the use of condoms through alliances with brothel managers. Because these two strategies have been successful, they should be intensified in order to increase condom use. Besides strengthening women's organization, prevention strategies should incorporate some components of the 100% Condom Use in Thailand. That is, programs should involve active participation and commitment from the government and from owners of sex establishments. Furthermore, establishments that fail to follow the norm should be punished. Therefore, as in the Thai case, prevention strategies should require sex workers to use condoms with all their clients, require the brothels to enforce and demand use of condoms, protect sex workers from difficult clients, monitor that brothels actually enforced the use of condoms, and punish the brothels that do not comply with the norm.[67] Because many sex workers in Honduras are street-based, condom use should be reinforced by community led interventions that involve sex workers and their clients.

Systematic involvement of customers:

Because one reason for the lack of condom use is the lack of commitment from clients, programs should include systematic interventions with clients and sex workers' partners. One of Sonagachi's programmatic approaches was accepting clients as allies of the project.[11] As a result, the project addressed interventions to customers by identifying leaders who were respectful with sex workers and were willing to use condoms. These clients worked as peer-leaders to educate other clients. As product of the education programs, customers organized themselves to support prevention strategies and to reduce violence against women. As part of the program, clients accessed health care and counseling.

Organized women as a core element of interventions

Finally, the organization of Women United for the Control of STIs and HIV/AIDS represents a structural facilitator that reduces women's vulnerability, because it empowers them, reduces costs of the interventions and increases ownership. In order for the programs to be sustainable to be sustainable, sex workers' participation should be a core element of all interventions. For this purpose, the program should strengthen this organization and support its members in order get legal recognition. Prevention strategies should be based on sex workers and their needs as a basic foundation of interventions.

[11] Personal communication with Dr. Smarajit Jana Principal, Sonagachi Research & Training Institute, Kolkata, India and Lecture Enhancing gender equity in HIV intervention program, a unique model- designed by DMSC. University of Texas, November 13th, 2009

The active participation of women and community empowerment will increase community ownership ensuring the effectiveness of prevention strategies. The interventions will not have difficulties reaching sex workers if sex workers themselves are running and implementing the strategies. This high participation will ensure that the programs will have a greater magnitude.

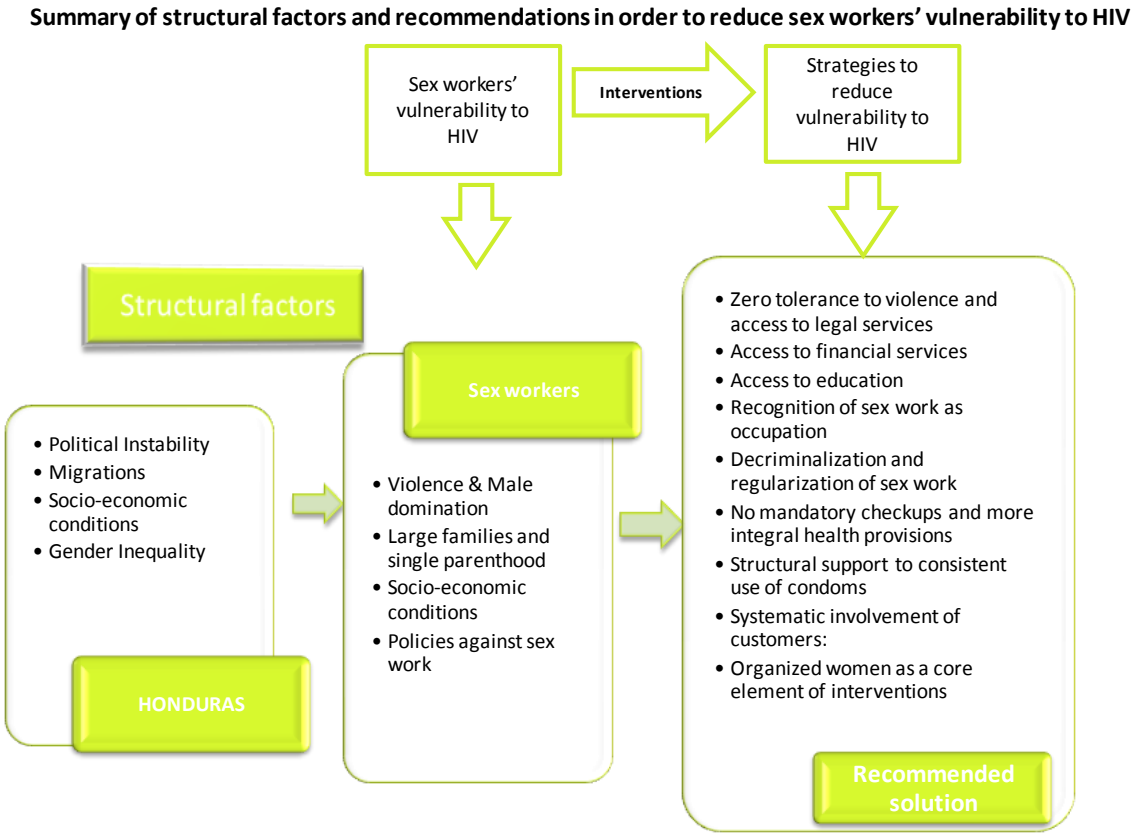

Figure 20: Summary of structural factors at the national and population levels, and recommendations

Figure 20 is a summary of the main findings and recommendations of this report. This report aimed to find out which strategies could realistically prevent HIV and

promote healthy behaviors in the long run among female sex workers in Honduras. In order to answer this question, I did an analysis of the structural conditions at the national level and at the population level. I found out that there are many structural factors that make sex workers vulnerable to HIV. Thus, effective and sustainable prevention strategies must aim at reducing female sex workers' vulnerability to HIV. The recommendations therefore, tackle those structural conditions. This report does not give specific details on how to implement each suggested programmatic activity. Therefore, further research in Honduras should focus more deeply on each factor, evaluating each of the current policies, such as the access to health services and the health card. This report gives evidence that current policies and interventions in Honduras should be reframed to take into account sex workers' needs, and their rights. This sounds obvious, but to date it is not what interventions are fully achieving.

Appendix A

OFFICE OF RESEARCH SUPPORT
THE UNIVERSITY OF TEXAS AT AUSTIN
P.O. Box 7426, Austin, Texas 78713 (512) 471-8871 -FAX (512 471-8873) North Office Building A, Suite 5.200 (Mail code A3200)

FWA: 2030
Date: 10/16/09

PI(s): Maria M Garcia
Peter Ward

Department & Mail Code:
LBJ SCHOOL, DEAN E2700

IRB Approval-IRB Protocol #: 2009-09-0009

EXEMPT DETERMINATION OF RESEARCH PROPOSAL

Title: HIV/AIDS, an Issue Bevond Health: The Case of Honduras

Approval Period: 10/15/2009 10/14/2010 *(expires 12am [midnight] of this date.)*
This research project has been approved for a period of up to three years.
Approval determination was based on the following Code of Federal Regulations:
45 CFR 46.101(b):

(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Responsibilities of the Principal Investigator(s):
Research that is determined to be Exempt from IRB review is not Exempt from protection of the human subjects. The following criteria to protect human subjects must be met:

1. The investigator assures that **all investigators and co-investigators are trained in the ethical principles**, relevant Federal Regulations and institutional policies governing human **subject research**;
2. The investigator assures **that human subjects will voluntarily consent to participate** in the research when appropriate (e.g. surveys, interviews) and will **provide subjects with pertinent information**, e.g. risks and benefits, contact information for investigators and IRB chair, etc.;
3. The investigator assures that **human subjects will be selected equitably**, so that the risks and benefits of the research are justly distributed.
4. The investigator assures that the **IRB will be immediately informed of any information, unanticipated problems** that would increase the risk to the human subjects and cause the category of review to be upgraded to Expedited or Full Review;
5. The investigator assures that the **IRB will be immediately informed of any complaints** from participants regarding their risks and benefits; and
6. The investigator assures that **confidentiality and privacy of the subjects** and the research data will be maintained appropriately to ensure minimal risk to subjects.

The above criteria are specified in the PI Assurance Statement and as the Responsible Investigator, you acknowledged you understood and accepted these conditions with the submission of your protocol. Investigators can refer to the University website www.utexas.edu/irb for specific information on training, voluntary informed consent, privacy, and how to notify the IRB of unanticipated problems.

1. **Closure:** Upon completion of the research project, a closure request must be submitted to the Office of Research Support (ORS).
2. **Unanticipated Problems:** Any unanticipated problems or complaints must be reported to the IRB/ORS immediately. For a description of unanticipated problems, please refer to the ORS webpage: http://www.utexas.edu/research/rsc/humansubjects/policies/section7.html#7.3
3. **Informed Consent:** The informed consent procedures laid out within your research proposal must be followed.
4. **Continuing Review:** If the study will continue beyond the approval period, a continuing review application must be filed.
5. **Amendments:** Amendments do not need to be filed with the ORS if the amendments do not change the risk level of the study (for example: increasing sample size, adding or removing co-PIs, adding or removing research sites, or minor modifications to the research protocol that do not affect the risk level). Changes that alter the level of risk to participants must be requested by submitting an amendment application and revised proposal to the ORS prior to those changes being implemented. For a description of the types of modifications that require an amendment application, please refer to the ORS webpage: http://www.utexas.edu/research/rsc/humansubjects/policies/section6.html#635b , or call 471-8871.

If you have questions, please call your IRB Program Coordinator for consultation.

Thank you for your help in this matter.

Sincerely,

Jody Jensen, Ph.D., IRB Chair

Appendix B

Carmen,
Salvando Vidas Gracias al uso Correcto y Consistente del Condón

Con miradas desganadas e inexpresivas, las veintidós mujeres escuchan a Carmen. Carmen Fandino o Carmencita, como las asociadas al gremio la llaman, una mujer de 49 años de edad, 180 libras de peso y un metro 60 de estatura, habla con la propiedad que le da el haber ejercido el trabajo sexual durante 12 años. "Papito, mi amor, quiere que le ponga su condoncito?", dice Carmen quien logra articular las palabras perfectamente aún después de haberse puesto el condón dentro de la boca. Simulando que está hablando con un cliente, toma el dildo de madera entre sus manos, y con una maniobra sorprendente, logra ponerle el condón al artefacto sin permitir que sus manos lo toquen directamente.


Carmen, taller Amapala

Las mujeres entran en ambiente, al punto de que una de las mayorcitas –más de 60 años quizás- cuenta que alguna vez usó una bolsa plástica porque no tenía condones. Algunas se ríen con la anécdota, pero nadie se sorprende. Las caras tensas ceden un poco. Se siente más la camaradería entre ellas. Todas se conocen y saben que se dedican a lo mismo; pero nadie quiere reconocer que están allí por ser trabajadoras sexuales anónimas.

En Amapala, uno de los principales puertos del pacífico hondureño, el trabajo sexual fue prohibido desde los años 90. Como era de esperarse, esta medida no eliminó ni la oferta ni la demanda, pero sí incrementó la vulnerabilidad de las mujeres que ahora lo ejercen sin controles sanitarios ni normas que las protejan de la violencia sexual. Según el doctor del pueblo, Armando Salvador Carranza, lo que hizo la prohibición fue mandar a las trabajadoras a la informalidad y a la clandestinidad. Ahora, quienes desean tener sus encuentros casuales van a donde La Coneja, una señora que, además de vender vinagre de piña, alquila cuartos hasta por diez lempiras. Así que cuando uno de los más de 11 mil habitantes del pueblo decide usar los servicios de La Coneja, el chiste común entre los amapalinos es que se va a ir a comprar vinagre.

Carmen habla cada vez más abiertamente sobre el tema de la sexualidad. La especialidad de Carmen es enseñar las técnicas de postura del condón masculino, con la mano, con la

boca, con el pie y con los ojos cerrados. De esta manera las trabajadoras sexuales no sólo logran no infectarse de VIH-SIDA, sino que también adquieren nuevas habilidades que atraen a los clientes al uso del condón.

Después de tres horas de hablar sobre sexualidad, autoestima, respeto y salud sexual, llega el momento por el cual muchas decidieron asistir a la capacitación: la hora del almuerzo. Mientras comen, muchas acompañadas por sus hijos pequeños, cada una de las mujeres recibe 15 condones y seis folletos informativos sobre los temas del taller. Este es sólo el primero de varios encuentros que tendrán como objetivo la prevención de la transmisión del VIH y la adopción de conductas saludables entre las trabajadoras sexuales, una de las poblaciones más vulnerables por sus condiciones de pobreza, la falta de oportunidades laborales y su bajo nivel de educación.

Carmen es funcionaria de la Asociación Cultural RIMAS, una de las organizaciones con las que la Asociación Médica de Doctores de Asia-AMDA implementa el proyecto de Fortalecimiento de la Respuesta Nacional de Promoción y Protección en VIH/Sida. Después de 12 años de estar en el oficio, Carmen dejó de ser una mujer trabajadora sexual-MTS para convertirse en facilitadora y formadora en los talleres de prevención del SIDA. En el último año Carmen ha capacitado a 400 MTS del proyecto Salvando Vidas, y también ha sido un testimonio de vida, pues logró salir de su situación y conseguir un buen trabajo para mantener a sus cinco hijos.

Carmen y las otras dos funcionarias del proyecto apoyado por el Fondo Mundial-CHF Internacional, parten rumbo a Choluteca, ciudad ubicada a una hora de Amapala. En la noche, el grupo de mujeres debe visitar a las trabajadoras sexuales cautivas en tres bares: La Troca, Los Almendros y La Barena. El objetivo es hacer un seguimiento a las muchachas que ya participaron en las capacitaciones y distribuir condones entre ellas para su protección y prevención del VIH/SIDA. Las mujeres son consideradas cautivas porque muchas de ellas viven en su lugar de trabajo y pagan por el uso de las instalaciones.

Maritza, una de las trabajadoras del bar La Troca paga 50 lempiras a Blanca, administradora y hermana del dueño del lugar, cada vez que va a usar el cuarto. Maritza empezó a trabajar en el bar hace tres años, cuando su marido se fue para Estados Unidos y la dejó sola con sus cuatro hijos. Maritza les cobra a casi todos sus clientes un promedio entre 150 y 200 lempiras. Al único que no le cobra es al hombre que empezó siendo su cliente, pero que ahora es su marido. A él ni le cobra, ni le exige el uso del condón. Él la persuadió de no usar protección con el argumento de que no quería tratarla “como si fuera una prostituta”. Aunque ella cree que él no le es fiel y a pesar de haber participado en diez charlas sobre VIH, esta mujer de 36 años decidió no usar protección, como si el VIH no se transmitiera cuando las personas tienen sexo por amor.

Maritza no es la única que toma este riesgo. De hecho sólo un 30% de las MTS usa condón con sus parejas estables. Esta práctica se ha convertido en un desafío que el proyecto está tratando de enfrentar. De acuerdo con Lessa Medina, coordinadora de AMDA, existen condiciones socioculturales de esta población que no pueden ser cambiadas en el corto plazo, sino que tienen que ser abordadas en el largo plazo. Estas

condiciones generan otras prácticas que aumentan el riesgo de la transmisión del VIH. Por ejemplo, en el segundo bar llamado Los Almendros, Paola, otra MTS de 29 años de edad y con dos hijos, confiesa que existe una práctica entre ellas a la que va a ser difícil renunciar: el uso de dos condones por relación. Aunque han recibido información sobre el alto nivel de protección que un condón brinda, Paola explica que muchas de ellas se sienten más seguras cuando usan dos.


Trabajadora Sexual, La Barena

A pesar de lo difícil que ha sido el trabajo con las MTS, el proyecto ha tenido grandes logros. Rosaura, administradora y trabajadora de la Barena cuenta que el proyecto le ha servido como terapia psicológica, porque la ha llevado a pensar en su valor como persona y el valor de su vida. Ahora sabe que con ciertas prácticas y comportamientos puede poner en riesgo su vida. Y es que los riesgos del VIH han estado muy cerca de ella. Esta administradora de empresas de 39 años de edad y belleza angelical, lleva 15 años trabajando en el negocio y desde entonces ha visto morir de SIDA a tres de sus compañeras.

Por esta razón, como administradora del bar, Rosaura ha permitido a Rimas dar charlas sobre prevención del VIH, sexualidad y autoestima. Según Rosaura, muchas de las MTS han tomado conciencia de la importancia del uso del preservativo para salvar sus vidas. Rosaura no es la única administradora de bar comprometida con el proyecto. AMDA está trabajando con otros 23 bares, en donde se ha capacitado a 300 mujeres. La capacitación en bares ha sido una de las estrategias más exitosas de acercamiento a la población cautiva. Estas mujeres reciben también el seguimiento de los funcionarios de Rimas y de AMDA y, aunque los resultados de esta estrategia son difíciles de cuantificar, tanto Maritza, como Paola y Rosaura, expresan que con las visitas ellas sienten que alguien las valora.

El impacto en la vida de Carmen ha sido enorme. Primero le sirvió para reconocer que era una trabajadora sexual; por ser anónima no se consideraba una de ellas. Ahora Carmen tiene comportamientos muy diferentes. Con su marido no sólo ha logrado consensuar el uso del condón, sino que también ahora tiene una relación basada en el respeto mutuo. Hoy en día Carmen es la coordinadora de una organización conformada por 1.700 MTS, porque cree firmemente que sólo organizándolas, estas mujeres van a entender y a exigir sus derechos. Su último logro ha sido aprender a leer y a escribir. A sus 49 años esta mujer no sólo logró volverse productiva e influyente, sino que ahora

también es capaz de escribir con su puño y letra su nombre, “Carmen Fandino”. Esto realmente la enorgullece.

Taller en Amapala con trabajadoras sexuales clandestinas

Appendix C

Questions for sex workers:

Name:
Age:
Occupation:
Number of Children:
How long have you worked as a sex worker?
How often do you work as a sex worker?
How many customers do have per day?
How many condoms do you monthly receive:
Do you know about HIV: SI__X___ NO_____
Do you know about methods of transmission
Do you know how to use condoms correctly?
How many condoms do you use per month?
How many condoms per month do you have access to?
If you have to buy condoms, how much it each condom costs? Where do you get condoms?
From whom you have received information about HIV?
Do customers offer more money to not use condoms?
Ever customers have mistreated you because you want to use a condom?
Did you suffer from sexual violence as a child?
Do you use alcohol or drugs when you are working? Yes ____No _____
Do you belong to any organization of sex workers?
Do you have access to health services?
How often do you see a doctor?
Have you felt discriminated against because of your profession?
How do police treat you?
Have you participated in any workshop on HIV prevention?
Have you participated in any other activity?
Would you like to have another job?
Why you don't get another occupation?

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Vita

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